Governor's Office for

Children and Families

SYSTEM OF CARE TOOL KIT

We Unite and Empower
Communities So They can
Unite and Empower Families

SYSTEM OF CARE TOOL KIT

The Governor's Office for Children and Families provides grants and technical assistance to Georgia communities to build their capacity to help improve outcomes for their children, youth, and families. The Governor's Office for Children and Families focuses on improving the welfare of children and youth through a Systems of Care approach in which communities coordinate and integrate their prevention and intervention programs in the areas of child maltreatment, juvenile delinquency, and youth development.

Developing and implementing a System of Care framework involves many components, activities and strategies – from how to build community partnerships and collaboration; engage and partner with families; provide culturally and linguistically competent services; provide evidence-based practices; to evaluation and sustainability. This Tool Kit is designed to assist community partners in creating an effective System of Care approach in providing services to children and families in their communities.

There are nine (9) sections within the Tool Kit covering the major building components helpful in designing and sustaining a System of Care framework:

- Section 1 – Introduction and Overview
- Section 2 – Forming and Sustaining Community Partnerships and Collaboration
- Section 3 – Population of Focus
- Section 4 – Family and Youth Partnership and Engagement
- Section 5 – Cultural and Linguistic Competency
- Section 6 – Service Delivery
- Section 7 – Accountability
- Section 8 – Sustainability
- Section 9 – Grant Writing

Each section in the Tool Kit includes narrative defining the topic, questions that should be addressed by the community that relate to the development of the particular aspect of system of care, and "tools," such as self-assessment instruments, surveys, helpful links to websites, resources, and articles related to the topic.

Over the twenty-five years from the initial publication of the System of Care definition, framework, and philosophy at the national level, many resources and tools have been developed across the United States. This Tool Kit provides a useful, updated compendium of information generated over the years across the country.

The System of Care Tool Kit was created to support local communities in the ongoing implementation of the System of Care approach across Georgia and serves to enhance the overall quality of system of care development through a coordinated, consistent approach to information sharing.

TABLE OF CONTENTS

Section 1 INTRODUCTION AND OVERVIEW

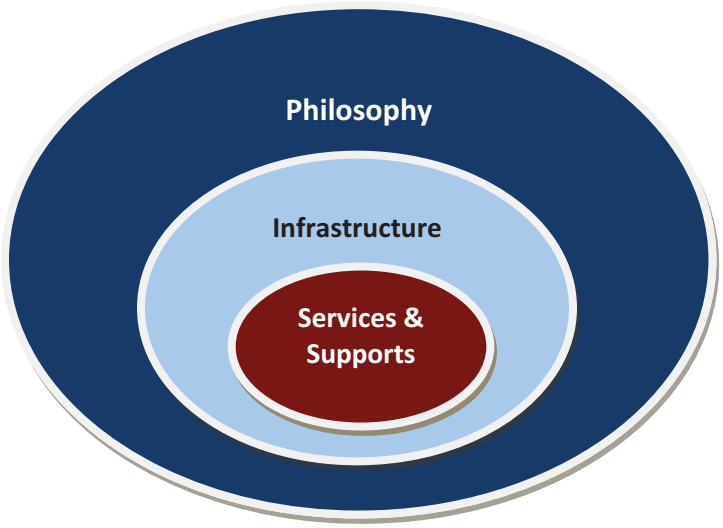
What is System of Care?

System of Care (SOC) is a nationally recognized framework for organizing and coordinating services and resources into a comprehensive and interconnected network. The goal is for service providers, child caring agencies, and community stakeholders to work in partnership with individuals and families who need services or resources from multiple service agencies to be educated, healthy, safe, and growing.

The system of care concept was first published in 1986 for children and adolescents with mental health challenges. Now twenty-five years after the initial publication of the System of Care definition, values, and principles, the System of Care concept is widely accepted and used across various service systems, states, and local communities. The recent Issue Brief "*Updating the System of Care Concept and Philosophy*" [1] underscores the dynamic nature of the SOC construct, as well as the endurance of the values and principles as fundamental to the SOC approach. The current definition of System of Care as presented in the Issue Brief is:

> ***A spectrum of effective community-based services and supports for children and youth with, or at risk for, mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them function better at home, in school, in the community and throughout life.***

"At the most basic level, a system of care can be understood as a range of services and supports, guided by a philosophy, and supported by an infrastructure."



[1] Stroul, B., Blau & Friedman. (2010) *Issue Brief: Updating the System of Care Concept and Philosophy.* Washington, D.C.:Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health

CORE VALUES[2]

Systems of Care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES[3]

Systems of Care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries, and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure multiple services are delivered in a coordinated and appropriate manner and children and their families can move through the system of services to meet their changing needs.

[2] Stroul

[3] Stroul

8. Provide developmentally appropriate services and supports that promote optimal social-emotional and behavioral outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with prevention, and early identification and intervention programs in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and appropriate prevention activities (based on the population of focus) directed to all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

The intent of the system of care concept is to provide a framework and approach to guide service systems to improve the lives of children and their families – NOT to propose a "model" for replication. Different communities implement systems of care in different ways; each community must engage in its own process to plan, implement, and evaluate its system of care based upon its particular needs, goals, priorities, populations, and environment.[4]

A Brief History

- In 1983, the National Institute of Mental Health initiated the *Child & Adolescent Service System Program (CASSP)*, which provided federal funds and technical assistance to all fifty states and a number of local jurisdictions to plan and begin to develop systems of care for children with serious emotional disturbance
- In 1986 the first definition of system of care for children with emotional disorders was published
- In the mid-1980s a growing family movement gathered strength, and a national, organized family voice emerged with the creation of the Federation of Families for Children's Mental Health in 1989
- In 1992 Congress passed legislation creating the Comprehensive Community Mental Health Services for Children & their Families Program within the Substance Abuse and Mental Health Services Administration (SAMHSA) – the major federal source of funding for local system of care development

[4] Stroul

- Since the first grants were awarded in 1993, approximately 150 local communities have received federal grants for local system of care development, including two sites in Georgia

There is a considerable and rich history of systems of care across the nation. While it started as a response to the multi-faceted needs of children with serious emotional disorders, "it has evolved over time as a concept that can be applied to any designated population of children, youth, and families that require an array of services and supports from multiple entities, including any or all populations of children, youth and families involved, or at risk for involvement, in the child welfare system."[5]

The Georgia Experience

- Early 1980s, The State Troubled Children's Committee was created with pooled funds from child welfare, juvenile justice, and mental health to fund residential placements for children with significant challenges
- Local level Troubled Children's Committees (later known as MATCH) were established with technical assistance from CASSP
- In 1990, the state legislature passed a bill that put system of care in law, specific to mental health: Georgia Code 49.5.220
    - Ensure a comprehensive mental health program consisting of early identification, prevention, and early intervention for every child in Georgia
    - Preserve the sanctity of the family unit
    - Prevent the unnecessary removal of children & adolescents with a severe emotional disturbance from their homes
    - Prevent the unnecessary placement of these children out-of-state
    - Develop a coordinated system of care so that children and adolescents with a severe emotional disturbance and their families will receive appropriate educational, non residential and residential mental health services, and support services, as prescribed in an individualized plan
- In 1999, Rockdale County was awarded a local system of care federal grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop infrastructure and services for severely emotionally disturbed children and adolescents.
- In 2004, Georgia was awarded two federal grants – the Child & Adolescent State Infrastructure Grant (CASIG) and the State Adolescent Coordination grant (SAC) to build statewide

[5] Pires, S. (2008). *Building Systems of Care A primer for child welfare.* Washington D.C.: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health

infrastructure to support systems of care for severely emotionally disturbed children and adolescents

- In 2005, the Commission for a New Georgia recommended establishing a state-wide single system of care for emotionally disturbed children and adolescents with: Evidence-Based Practices (EBP); case manager accountability; non-duplicative services; blended funding

- In 2008, the Governor's Office for Children and Families was created with the mission "to empower Georgia communities to achieve improved and sustainable outcomes by working in a systems of care framework, which will ensure that all children and families are educated, healthy, safe, and growing."

- In 2008, Northwest Georgia was awarded a regional (multi-county) system of care federal grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop infrastructure and services for emotionally disturbed children and adolescents

- In 2009, the Governor's Office for Children and Families awarded the first round of system of care Caring Community grants with a focus on prevention and intervention programs in the areas of child maltreatment, delinquency, and youth development.

- In 2010, the second and third round of Caring Community grants were awarded

Helpful Information Resources

www.children.georgia.gov: website for the Governor's Office for Children and Families

www.kids.georgia.gov: The Strengthening Communities' website provides Georgians with web-based access to thousands of statewide services.

http://children.georgia.gov/00/channel_modifieddate/0,2096,113927404_114432859,00.html – direct link to Building Systems of Care: A Primer, by Sheila Pires

www.systemsofcare.samhsa.gov: Substance Abuse and Mental Health Services Administration website

www.childwelfare.gov/pubs/soc: U.S. Department of Health and Human Services, Administration for Children and Families website for system of care

www.tapartnership.org: Website for the Technical Assistance Partnership for System of Care – Georgetown University; tab – System of Care

Section 2 FORMING & SUSTAINING COMMUNITY PARTNERSHIPS & COLLABORATION

What is a Community Partnership?

Community partnerships are relationships between agencies and stakeholders to address an identified community issue. Community partnerships help communities shape strategies to address identified issues by building a network of services based on their own cultures, needs, and resources. The Community Partnership (collaborative) may serve as an Advisory Board to the community system of care.

What is Collaboration?

Working collaboratively is a key component and driving force in developing systems of care. Collaboration is defined as "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone."[11]

The goal of collaboration is the establishment of a process for problem solving, rather than an end result in itself. In essence, collaboration changes the way organizations work together. Collaboration moves organizations from competing to building consensus; from working alone to including others from diverse fields; from thinking mostly about activities, services, and programs to looking for complex, integrated interventions; and from focusing on short-term accomplishments to broad system changes.[12]

Collaboration should not be confused with the ideas of cooperation and coordination, which support and contribute to the development of collaboration. Cooperation is the "first step in collaboration – people agree to help each other in specific ways"; coordination is "the second step in collaboration – you help each other out, but no one changes the way business is done." Collaboration is achieved once everyone places their own issues aside and blends their efforts to make something new happen.[13]

Assessing Readiness for Collaboration

Prior to forming a community partnership/collaborative, it may be necessary to conduct a formal or informal assessment to determine the community's readiness and capacity for developing a partnership.

Refer to the Collaboration Readiness Checklist in Appendix A.

Identifying Potential Partners

Committed, hard-working members are the foundation of a thriving community partnership; they should represent a diverse group of people from various agencies, organizations, and community groups, as well as individuals who are involved in the identified community issue to be addressed.

Possible community partners include:

- Families and youth from the target population, who have been, or currently are involved with service providers

[11] Winer, M & Ray, K. (1994) *Collaboration handbook: Creating, sustaining, and enjoying the journey.* St. Paul, MN:Amherst H. Wilder Foundation

[12] Winer, (1994).

[13] Forest, C. (2003) *Empowerment skills for family workers: A worker handbook.* Cornell University.

- Community professionals, such as school personnel, behavioral and physical health practitioners, child care providers, public and private child agency representatives
- Court and law enforcement personnel
- Public and private service providers
- Faith-based organizations
- Community/civic groups
- Private foundations and philanthropic organizations
- Businesses/Financial Institutions

Factors to Consider When Identifying Partners[14]

Number	Two few members may overburden the partnership, while too many may make it difficult to accomplish specific tasks or manage the group. A group of 12 to 15 individuals is usually considered ideal. If the partnership needs to involve more members in order to have all of the necessary partners represented, the partnership can establish subcommittees or workgroups for better manageability. Additionally, to keep the group from being too large, each participating organization should only have one representative, who can report back to the organization about the collaborative's proceedings.
Relationships	Personal or business relationships among members outside the partnership may affect the group; therefore it is important to be familiar with, and to understand those relationships, including prior history of partnerships. If mostly friends or colleagues are selected as members, decisions may be based on discussions or factors that occur outside the group and may cause divisions or a sense of exclusion within the group.
Leadership & Resources	The ability of a member to contribute time, skills, and resources to the partnership is critical. Consider leadership ability and assets that candidates will provide, based on their connections, job position, access to resources, and their skills, as well as the time they can invest.
Level of Influence	Some members may be included because they will attract other key individuals to the effort. Celebrities, government officials, and directors of large organizations may be magnets for committed, industrious individuals. Even if they do not stay with the project for long, these individuals may be important to helping the group form. It is equally critical to recognize the importance of grass roots and local community leaders.
Readiness for Collaboration	The organizations and individuals should believe that a collaborative process can make a change in the community. The political and social climate within potential partnering organizations should be favorable to participation.
Diversity	Businesses, community organizations, families and representatives from a variety of related fields and with shared interests should be recruited to ensure diversity within the partnership. In addition, the group should reflect the racial/ethnic diversity of the community.

[14] Brown, E.G., Amwake, C., Speth, T. & Scott-Little. C. (2002) *The continuity framework: Building home, school, and community partnerships.* National Network for Collaboration.

Section 2 FORMING & SUSTAINING COMMUNITY PARTNERSHIPS & COLLABORATION

Roles and Responsibilities of Partners

Collaboratives may serve any, or all of the following functions:

- Advisory group that guides the system and service delivery
- Overseers of service implementation, including entry/exit protocol development
- Coordinators and communicators of system related information
- Monitors of system implementation and practice change
- Advocates for children and families
- Plan developers

Responsibilities of collaborative members:

- Participate in determining direction of collaborative
- Prepare for, and attend meetings on a regular basis
- Serve as liaison to the represented organization; report progress of discussions to that organization and ensure that other members do the same for their organizations. Share concerns and ideas of the represented organization with the collaborative
- Invest in developing ground rules for group behavior
- Candidly share interests and concerns, and assure that others are invited to do the same
- Listen and fully understand the views of others
- Develop, conduct, and participate in the completion of a comprehensive community needs assessment
- Help develop and implement a strategic plan and in prioritizing goals and objectives into an action plan
- Serve on workgroups or committees internal to the collaborative
- Assist in implementing activities, including those that directly involve or relate to the represented organization
- Serve as a resource for the development of program activities
- Represent the collaborative at meetings and events as required
- Serve as ambassador for the work of the collaborative and promote its mission when and wherever possible
- Gather and relay appropriate information to the collaborative to serve as a basis for decisions
- Help to develop and implement a plan to develop resources to sustain the collaborative[14]

Some collaboratives use annual *commitment letters* to clarify members' roles, organizational intentions, and levels of support.

[14] Butterfoss, F.D. (2007). *Coalitions and Partnerships in Community Health.* San Francisco: Jossey-Bass. p.142

Example of a Letter of Commitment[15]

Our organization, _____, is committed to be an active member of the_____Collaborative. We are committed to the vision, goals, objectives, and strategies that have been and/or will be decided by the Collaborative. We are committed to the planning that such collaboratives undertake and understand that it will take time. We acknowledge the contributions and expectations of the other members of the Collaborative. As general evidence of our commitment, we agree to do the following:

- Appoint a representative to attend collaborative meetings and activities
- Authorize that representative to make decisions on our behalf
- Read minutes, reports, and newsletters to keep abreast of collaborative decisions and activities
- Disseminate relevant information to organizational members or employees
- Keep collaborative informed of our organization's related activities

Specifically, our organization will commit the following resources to the collaborative:

- In-kind contributions of staff time, material resources, meeting space, etc
- Access to our volunteers for collaborative tasks and/or activities
- A financial commitment for $_____.
- Provision of services

Formal Roles in the Collaborative:

- Chairperson
  - Oversees/facilitates meetings
  - May serve as ex-officio member of all workgroups/committees
  - Prepares or assists in the preparation of meeting agenda
  - Acts as spokesperson for the collaborative
  - Periodically consults with collaborative members on their roles and helps them assess their performance
- Vice- Chairperson
  - Performs the duties of the Chairperson in their absence
- Recorder/Secretary
  - Records deliberations of the group and disseminates such in a timely manner to members

The collaborative must define a method to choose officers, for example through nomination and voting, or appointment, or taking volunteers. Each office should have a written "job description" so it is clear what the collaborative expects from those in office.

[15] Butterfoss (2007).

Section 2 FORMING & SUSTAINING COMMUNITY PARTNERSHIPS & COLLABORATION

Bylaws/ Guidelines

Bylaws/Guidelines establish how business will be conducted. They serve as a guide for membership, structure of meetings, and how decisions are made by the group.

Following is an example of a format for Bylaws:

ARTICLE I
NAME

The name of this organization shall be _____

ARTICLE II
MISSION

It shall be the mission of the_____Collaborative to_____

ARTICLE III
GOALS

The goals of this collaborative are to:

-
-
-

ARTICLE IV
MEMBERSHIP

Section 1: Structure
- General membership
- Steering Committee (if applicable)
- Work Groups

Section 2: Roles
- Chair
- Vice-Chair
- Recorder/Secretary
- Work Group Chairs
- Work Group Members

Section 3: Recruitment
Section 4: Term of Membership and Attendance
Section 5: Vacancies
Section 6: Resignations

ARTICLE V
OFFICERS & DUTIES

Section 1: Officers and Terms
- How officers are elected
- Term of office
- Duties

Section 2: Work Group Chairs
- How elected or appointed
- Duties

ARTICLE VI
WORK GROUPS/COMMITTEES

The collaborative will form Work Groups to include, but not limited to:
- System of Care Administration
- Family Engagement and Participation
- Sustainability/Finance/Resource Development
- Evaluation

ARTICLE VII
MEETINGS

Section 1: Regular Meetings
- Frequency

Section 2: Open Meetings

Section 3: Quorum

Section 4: Correspondence and Notification of Meetings
- Minutes from each meeting will be disseminated within one week after the meeting
- Agenda and meeting notices will be distributed to members no later than one week prior to the meeting

ARTICLE VIII
PARLIAMENTARY PROCEDURE

Section 1: Rules of Order

Section 2: Conflicts and Decision Making
- How conflict will be handled
- How decisions will be made if consensus cannot be achieved or in the absence of a quorum

ARTICLE IX
AMENDMENTS

Initial and Ongoing Tasks of the Collaborative

Developing the Purpose, Mission and Vision Statements – the mission statement describes the purpose of the collaborative, or the fundamental reason for its existence. An effective mission statement is concise and easy to understand and to communicate to the community, stakeholders, general public, and funders. The mission statement should identify and include what the collaborative is going to do and why. The vision statement is a broader picture of a desired future described in the present tense. The collaborative must clearly define its vision and mission and assure that the goals derived from them reflect the self-interests of various member organizations as well as the more altruistic goals for the community good. A clear vision and mission can help generate support and awareness for the collaborative, identify partners, reduce conflict, and minimize distractions from appropriate actions.[16]

Developing the Values Statement/Guiding Principles – while the values/principles should include all of the system of care core values and principles, the collaborative may have additional values or principles that they want to include based on their unique community culture.

Developing By-laws – Bylaws or guidelines establish a structure for conducting business. See example of bylaws document above.

Developing the Strategic Plan and Action Plan - Strategic Planning is a systematic process by which an organization plans for the future, focuses limited resources into areas considered most beneficial by stakeholders, ensures continuity of decision making, promotes relevance as well as efficiency, and takes into account the community itself and its environment. The plan should reflect the purpose, vision, and mission of the partnership. In essence, the strategic planning process asks the organization to respond to four questions:

- Where are we now? (assessing)
- Where do we want to be? (planning/strategizing)
- How do we get there? (implementing)
- How do we measure our progress? (evaluating)[17]

The Action Plan is a detailed description of the tasks and activities in the implementation process. The components of a good action plan include: person/s responsible, date to be completed, resources required, action steps, and who needs to be involved.

Establishing Work Groups – The collaborative, as a whole, is not the best group for detailed work – the Collaborative should establish work groups or committees, make assignments, monitor progress, and review and evaluate final recommendations from committees/work groups.

[16] Butterfoss (2007).
[17] Butterfoss (2007)

Considering the following questions may assist the collaborative in deciding when work should be directed to committees or work groups:

- Does the task involve research or more investigation before a recommendation can be made?
- Is expertise needed from people other than collaborative members to ensure outcomes are achieved?
- Are there details that need to be thought through and drafted for the collaborative so that thoughtful deliberation can occur?
- Are there tasks specific to strategic planning that require committee work?

Once a work group/committee is determined necessary, consider the following:

- People are identified who have the skills and expertise necessary to accomplish the work
- Clear due dates/deadlines are set
- Obstacles to implementation are dealt with immediately at the collaborative level
- Progress reports are shared at every collaborative meeting by work group chair

Developing Memorandums of Agreement - Memoranda of Agreement (MOA) serve as an agreement among members, agencies, and service providers that reflect a commitment to principles, tasks, and funding that are necessary to accomplish the collaborative's goals.

Conducting Business - Meetings must be productive and useful or members will stop attending. Include the Purpose, Mission and Vision statements in the handouts, or post them, at every meeting; referencing these documents regularly helps the group to focus on the work to be done. Meeting structure should have:

- A process agreed upon by all members as how to conduct meetings (bylaws)
- A process that allows each member to participate and no one person to dominate
- Utilization of data
- A clear decision-making process
- Summary at the end of each meeting that details what was agreed upon during the meeting, what tasks were assigned, and solicitation of items for the next meeting agenda
- Documentation of meetings

Data is one of the greatest tools for the collaborative; data reflects trends in the system, what is working and what is not working. Reporting of data is one way to accurately inform the collaborative and funders of how the partnership is doing, how the system is doing and where to focus next. However, for data to be useful to collaborative members, each member should be able to understand data reports, and data must be related to the purpose and tasks of the collaborative.

Sustaining the Community Partnership/Collaboration

Sustainability refers to the collaborative's capacity to support and maintain its activities over time. In order to sustain a community partnership, it is critical to keep members interested and involved. Strategies include:

- Ensuring meetings are brief, focused, and productive
- Providing members with meaningful tasks that are suited to their interests and abilities
- Staying on track and continuing work toward the goals outlined in the strategic plan
- Highlighting successes and milestones, so that members can see progress and achievements
- Adapting to changes in the community
- Soliciting member input for ideas on improvement
- Having open, honest dialogues with ways to work through tension and conflict
- Orienting and recruiting new members as other members leave, move, or rotate off
- Reassessing work groups as they relate to the mission and vision; establish new work groups and sunset existing ones as needed
- Having retreats annually or regularly, as decided by the collaborative, to reestablish vision, mission, goals, and work activities
- Regularly conducting formal and informal training that give members the knowledge needed to be effective partners
- Making your collaborative important and necessary in the community

The Six "R's" of Participation:

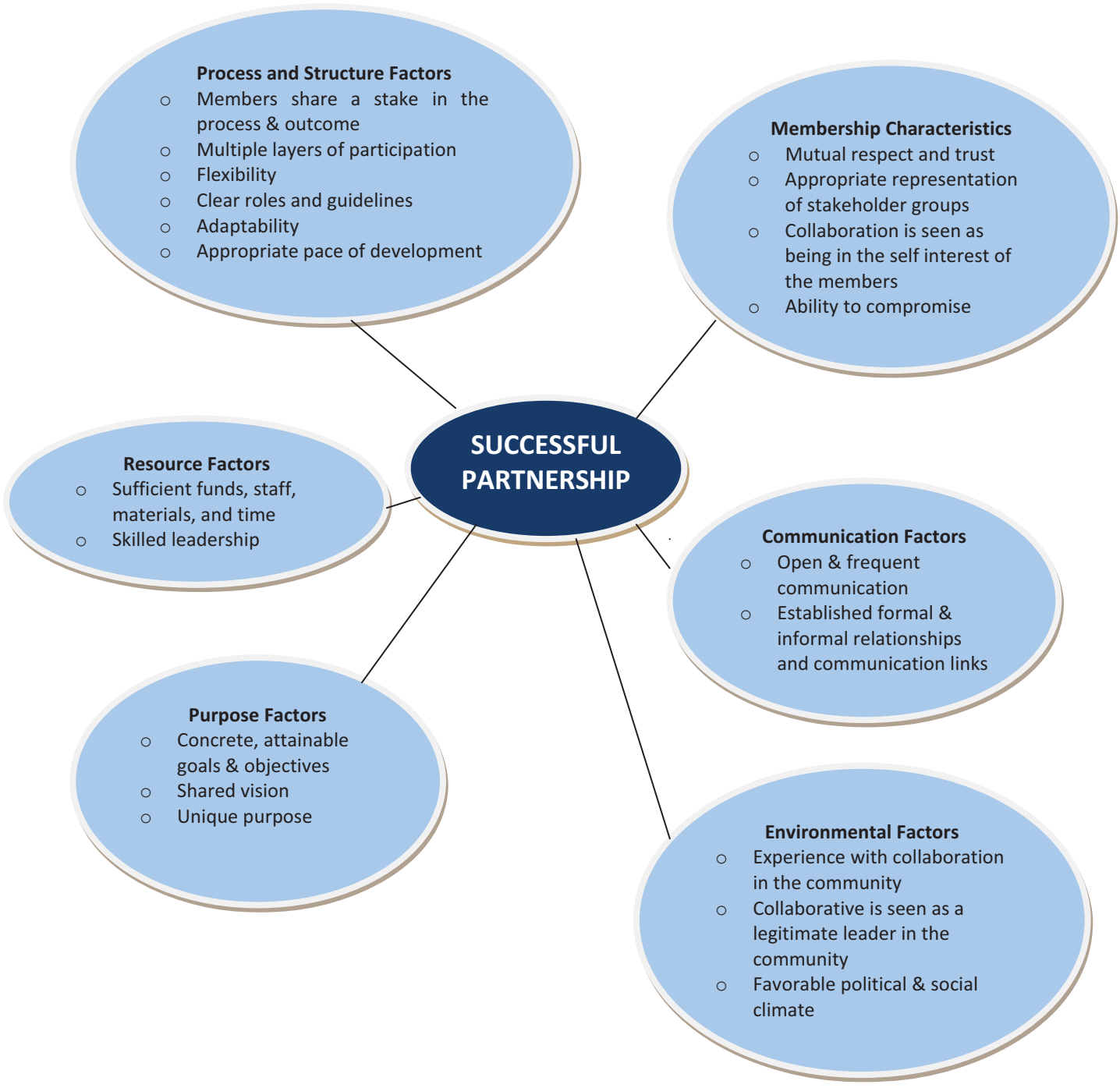
Members will continue to participate in collaboratives when they are:

- *Recognized* for their service
- *Respected* for themselves and their values by others
- Have a valued *Role* in the collaborative
- Have opportunities to network and develop *Relationships* with others
- Are *Rewarded* for their participation
- See visible *Results* for their efforts[18]

[18] Kaye, G. and Wolff, T. (eds). (1995). *From the Ground Up: A Workbook on Coalition Building and Community Development.* Amherst, MA: Area Health Education Center/Community Partners.

Section 2 FORMING & SUSTAINING COMMUNITY PARTNERSHIPS & COLLABORATION

Twenty Factors for Successful Partnerships[19]



[19] Mattessich, P.W., Murray-Close, M. & Monsey, B.R. (2001). *Collaboration :What makes it work* (2nd. Edition). Saint Paul, MN: Amherst H. Wilder Foundation

Section 2 FORMING & SUSTAINING COMMUNITY PARTNERSHIPS & COLLABORATION

Helpful Information Resources

www.cacsh.org – Website for the Center for the Advancement of Collaborative Strategies in Health; collaborative self-assessment instruments are available.

www.collaborativeleadership.org – Website for Collaborative Leadership for Public Health Leaders, includes training tools and self-assessment instruments.

www.tomwolff.com –Website providing tools and resources to mobilize the power of collaborative processes in communities

www.gafcp.org – Website for Georgia Family Connection Partnership

Two self-assessments are included in the Appendices – the first to assess readiness for collaboration and the second, a self-assessment for Advisory Boards to determine strengths and growth areas.

www.corporatevoices.org/our-work/workforce-readiness/ready-by-21 - The *Big Tent Stakeholders Wheel* located in Appendix C is included with the permission of the Corporate Voices in partnership with Ready-By-21 Partnership.

Section 3 POPULATION OF FOCUS

What is Population –Based Practice?

A "population" is a collection of individuals who have one or more personal or environmental characteristics in common; a population-at-risk is a population with a common identified risk factor or risk-exposure that poses a threat to well-being.[30] Population-based practice reflects the priorities of the community determined through a community assessment and emphasizes all levels of prevention:

- primary prevention promotes health and keeps problems from occurring;
- secondary prevention detects and treats problems early;
- tertiary prevention keeps existing problems from getting worse.

Effective collaboration is focused on a selected population-at-risk.

What is a Community Assessment?

A community assessment is an exercise by which a collaborative gathers information on the current strengths, concerns, and conditions of children, families, and the community; community assessments focus on local assets, resources, and activities, as well as gaps, barriers, and emerging needs.[31]

The process of conducting a community assessment involves:

- scanning the community to locate existing information
- developing a family focus
- identifying community assets and the degree to which they are accessible to the people who can benefit from them
- analyzing the information

Guiding Principles of Community Assessments[32]

The collaborative's vision statement should guide the assessment – the vision points to the information needed in order to take action.
Assessment is an ongoing process – ongoing assessment enables the collaborative to respond to changing needs and conditions.
An accurate assessment views the community from multiple perspectives – information from diverse stakeholders results in a more complete picture of the community; people's views vary regarding programs, agencies, services, and relationships depending on cultural , ethnic and economic circumstances.
An effective assessment takes an in-depth look at diversity within a community – ethnic groups may differ in their opinions about services, and there may be differences among first-, second-, and third generation immigrants.

[30] Williams, C.A. & Highriter, M.E. Community health nursing: population focus and evaluation. *Public Health Reviews.*1978, 7 (3-4):197-221
[31] U.S. Department of Education & Regional Educational Laboratory Network. *Putting the pieces together, comprehensive school-linked strategies for children and families.* Accessed at www.ncrel.org. 11.05.10
[32] U.S. Department of Education

Section 3 POPULATION OF FOCUS

Conducting the Assessment

Six Steps in Conducting a Community Assessment[33]

Step 1: Establish the What, Where, and Who

Step 2 Learn More About the What, Where, and Who

Step 3: Identify Community Resources

Step 4: Analyze and Learn From Your Data

Step 5: Develop an Action Plan

Step 6: Share What You Have Learned

Step 1: Establish the what, where, and who

What are the priorities?

- What are the most important issues facing the community
- What has been done to address these issues in the past
- Risk factors in the community, such as:
  - Adolescent alcohol, tobacco, and other drug use
  - Child abuse and neglect
  - Gang activity
  - Juvenile delinquency
  - Youth violence
  - Truancy
  - Low graduation rates
  - Placement of children in foster care
  - Unemployment
- Community initiatives, organizations that encourage positive youth development by promoting protective factors, such as:
  - Presence and involvement of caring adults in schools and community
  - Pro-social opportunities
  - Availability of neighborhood resources
  - Safe and stable environments
  - Positive attitude toward school

Where will efforts be concentrated?

- County
- City/town
- Neighborhood
- School district
- Judicial circuit

[33] Find Youth Info. Accessed at www.findyouthinfo.org/communityAssessment.shtml

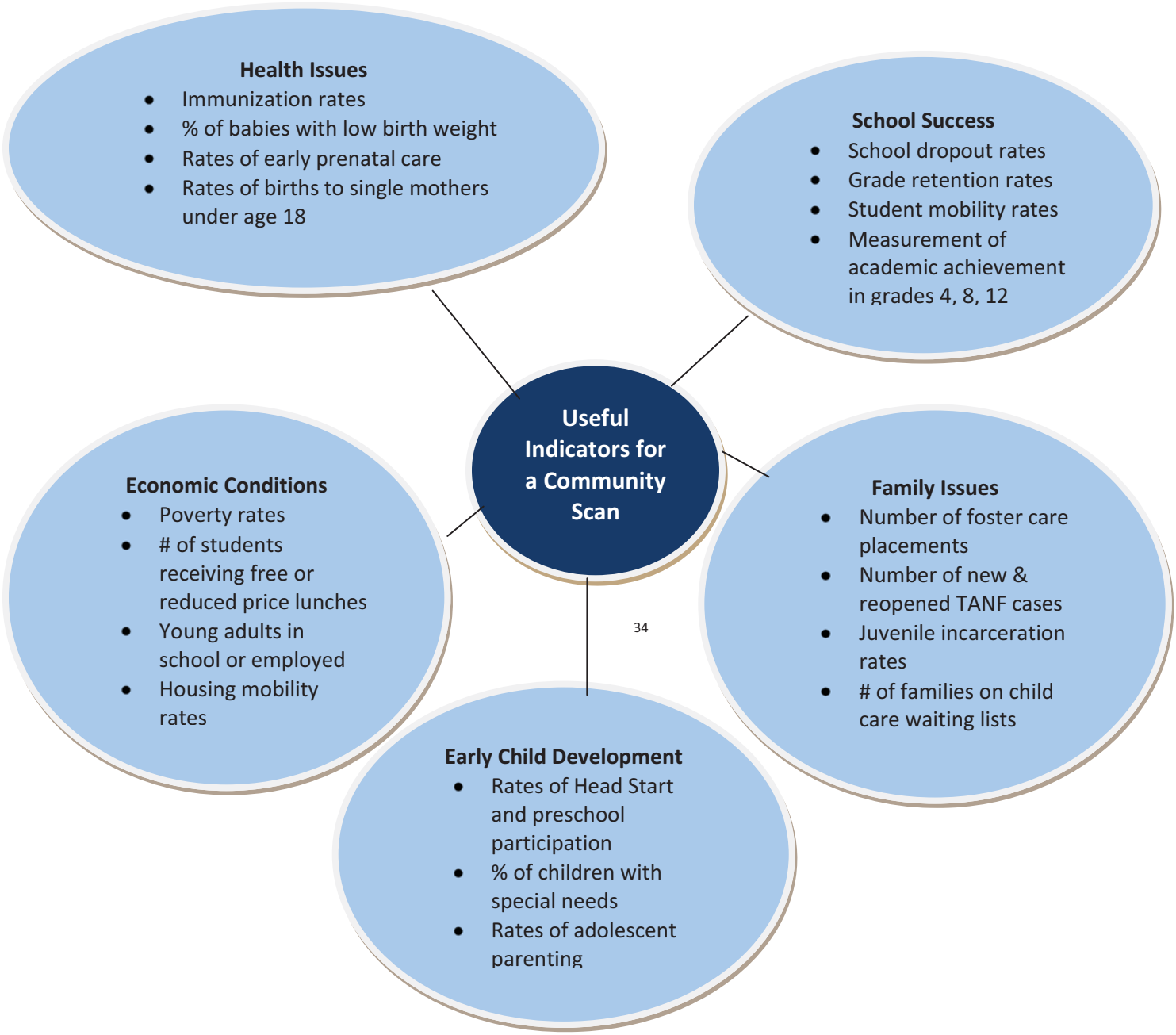
Section 3 POPULATION OF FOCUS

Who is the population of focus?

- Age, school level
- Risk factor

Step 2: Learn more about the what, where, and who (community scan)

Review relevant information from data resources – no single data source can provide a complete picture; by drawing from multiple sources, the accuracy of the assessment is improved.



[34] U.S. Department of Education

Section 3 POPULATION OF FOCUS

Information is available through the local health department, child serving agencies, school districts, chambers of commerce, law enforcement, census reports, etc.

New information can be garnered through surveys, focus groups, community forums, and individual or key informant interviews. It is particularly important to solicit information from families regarding convenience of existing services and gaps in services.

To compare issues and choose the best one for the collaborative to focus on, the following checklist may be useful to generate discussion and resolution.

Checklist for Choosing Collaborative Issues[35]

Will the issue (or resolving the problem)……..	***Yes***	***No***	***Unsure***
Result in a real improvement in children's & families' lives?			
Give families a sense of their own power?			
Build strong, lasting organizations?			
Raise awareness about democratic rights?			
Change power relations?			
Be worthwhile?			
Be winnable?			
Be widely felt?			
Be deeply felt?			
Be easy to communicate and understand?			
Provide opportunities for people to learn about and be involved in decisions?			
Have clear advocacy targets?			
Have a clear, feasible timeline?			
Be non-divisive among potential partners and population of focus?			
Build accountable leadership?			
Be consistent with community values and vision?			
Provide potential for developing resources and raising funds?			
Link local issues to regional, state, or national issues?			

For each potential issue, place a check mark under Yes, No, or Unsure. If an issue generates unsure checks, further research should be done to clarify the issue. Those issues receiving the most "yes" responses should be the issues considered to take action on.

[35] Butterfoss (2007)

Step 3: Identify Community Resources (Community Mapping)

Before a collaborative can design strategies to achieve goals, it must know what assets are available for utilization. Assets include individuals, organizations, and institutions – understanding what these assets are, how they are used, how they *could* be used, and how families do, or do not, access them, will assist the collaborative in choosing strategies that "fit" the community.

Community mapping takes inventory of the specific skills, services, and capacities of people, informal community organizations, and formal institutions. Build a community resource inventory to identify and track the following:

- Services and programs that may serve the population of focus and families, including formal child serving agencies, voluntary organizations, faith-based organizations, recreational/sports programs, community service initiatives, etc.
- Financial resources, including federal and state grants, foundations, non-profit organizations, donations, etc.
- Material and in-kind resources, such as office space, supplies, equipment, etc
- Human capital (staff, volunteers, champions)
- Training and technical assistance services and how to access them

The list of assets can be presented in several different ways, for example, alphabetically, geographically, or by function. It may be useful to use a street map of the community and to mark locations of community institutions, groups, and organizations with symbols to display patterns – for example, some areas have many different resources readily available, and others have none.

Step 4: Analyze and learn from the data

The data should answer the following questions:

- What child/youth related challenges and community attributes have been identified?
- What are the community's strengths in addressing these issues?
- What specific programs, organizations and initiatives already exist in the community that is addressing these issues?
- Which risk factors contribute to the community's problems?
- Which protective factors can help solve them?
- Which geographic areas and demographics are most affected by these issues?
- Where are resources located geographically?

- How does the data compare with the collaborative's initial understanding of these issues?
- What additional data does the collaborative need to better understand the scope of these issues?

Step 5: Develop an Action Plan

A good action plan describes how goals and objectives will be implemented and includes the activities that will advance the collaborative mission. An action plan provides direction – the specifics of who will do what, by when, and at what cost. The action plan should answer the following questions:

- What risk factors do you hope to mitigate?
- What protective factors are you planning to enhance or implement?
- How do you plan to advance the messages of prevention and positive youth development?
- Which organizations/programs in the community are already addressing the issue, and how does your initiative fit in with, or add to, the work already being done?
- Who are the partners who can assist in implementing the initiative?
- What do you need to implement your activities (such as funding, training, technical assistance) and who will provide that support?
- What are the specific outcomes you hope to achieve?
- What measures will you use to determine the success of your action plan?

Strategies/activities might include:

- *Providing information/enhancing skills*, for example hosting a professional conference
- *Enhancing services or supports*, for example implementing a home visitation program in an area with limited transportation
- *Modifying access, barriers, or opportunities*, for example developing a mobile immunization program in rural areas
- *Changing consequences of efforts*, for example providing incentives for volunteers
- *Modifying policies*[36]

[36] Butterfoss (2007)

Step 6: Share what you have learned

Planning, implementing, and sustaining a community initiative requires the support of the community at large. Share the information gleaned from the community assessment with partners and community stakeholders.

Questions to consider prior to writing a report:

- Who will coordinate the writing process?
- What information should be included?
- Who is the audience?
- Who from the community needs to be involved in dissemination?

The report should include:

- An introduction as to why the assessment was conducted
- Key findings and the central issues that emerged
- Identified risk factors and the community perceptions that will need to be considered in addressing these challenges
- Community strengths and resources to address the challenges
- New strategies the collaborative will implement (action plan)
- Measures that will determine whether the action plan is successful
- The challenges/barriers to be addressed to achieve success
- Conclusions and an invitation for the "audience" to get involved.

Population of Focus

Based on the findings of the community assessment, the population of focus must be determined. Considerations may include:

- *Demographics:* infants/toddlers, school-age children, transition-age youth, children over-represented by race or ethnic group in child welfare/juvenile justice populations
- *Intensity of system involvement*: multi-system involvement, risk for out-of-home placement, repeat maltreatment, repeat juvenile offender, etc.
- *At risk characteristics*: teen mothers, families in which substance abuse is occurring, families at risk of child protective services involvement, etc.

- *Level of clinical/functional impairment*: children with chronic health conditions, children with emotional disorders, children with developmental disabilities, etc.[37]

The strengths and needs of the population of focus will drive the types of strategies, services, and supports that will be required by the System of Care and the stakeholders who will need to be involved. For example, if the system is focusing on infants and their families, partners should include primary care practitioners, early intervention programs, Head Start, etc. If the focus is on transition-age youth, partners should include vocational rehabilitation, public assistance, housing, etc.

Helpful Information Resources

www.findyouthinfo.org/communityAssessment.shtml: FindYouthInfo is a U.S. government website dedicated to creating, maintaining and strengthening effective youth programs. Website includes youth facts, funding information, and tools for community assessment, mapping federal resources and evidence-based programming.

www.ncrel.org/sdrs/areas/issues/envrnmnt/css/ppt/chap2.htm: How to conduct a community assessment, from Comprehensive School-Linked Strategies for Children and Families, North Central Regional Educational Laboratory**,** including strategies for focus groups, interviews, and public forums.

www.sdgr.org/ctcresource/: Website for Communities That Care (CTC), a coalition-based community prevention operating system that utilizes a public health approach to prevent youth problem behaviors; included assessment instruments, training modules, and tool kits.

http://gafcp.org/index.php/count/main/: Website for Georgia Family Connection Partnership link to Georgia Kids Count Data Center.

http://oasis.state.ga.us: The online analytical statistical information system of the Georgia Division of Public Health; includes vital statistics, youth risk behavior surveys, and population data.

www.rotary.org/ridocuments/en_pdf/605c_en.pdf: A community assessment tool, including survey example, how to conduct an asset inventory and community mapping, and how to conduct focus groups.

[37] Pires, S. (2008)

Section 4 FAMILY AND YOUTH PARTNERSHIP AND ENGAGEMENT

What is Family and Youth Partnership?

Family and youth (when age appropriate) partnership is a negotiated process in which representatives of the service system, the collaborative Advisory Board, and families and youth (when appropriate) can understand each other's roles and establish common ground in working together. In a fully realized partnership, families, youth, and professionals contribute in their own ways to **planning, delivery, and evaluation of services** for children, youth, and families.[46]

While there are many voices, representing many agencies/disciplines articulating the needs of families and children, no one can express the reality of families as legitimately as the real experts – the families themselves.[47] Family/youth partnership is a cornerstone of systems of care; it does not just happen, it must be planned.

Key Guide Points for Partnering with Families[48]

Guide points are arranged in three groups: considerations for a collaborative/service delivery system in its advance planning for partnering with families; considerations for the initial meetings; and long-term considerations for continual working together.

Advance Planning	**The expertise of seasoned family member mentors can help engage new family members who are just joining the group and can introduce them to the work of the group and how it functions.**	A family member mentor should be assigned the task of preparing and engaging other family members. It is essential that families not be intimidated or invited to be at the table as the sole "family token."
Advance Planning	**Family members need a bonafide role in partnership activities.**	To the extent that information can be provided in advance, family members will be able to participate and contribute as informed, equal partners; when family members are given tasks, they may also need access to the tools and resources necessary to perform the tasks (access to a computer, transportation assistance, etc.)
Advance Planning	**Cultural competence is necessary in understanding how to value, support, and engage families in all aspects of any program.**	Understand that different cultures define the concept of "family" in different ways and to respect the family's own definition; there are culturally based variations in how families may nurture their children, which are legitimate for that family.

[46] Kaufman, M. *Family-centered, culturally competent partnerships.* Systems Improvement Training and Technical Assistance Project. Institute for Educational Leadership. Washington D.C.

[47] Family Support America. *Family support and parent advocacy.* Current Family Support News (2000). http://familysupportamerica.org.

[48] Casey Family Programs and U.S. Department of Health and Human Services (2001). *Key guide points for partnering with families.* Washington, DC: Casey Family Programs, and US Dept of Health and Human Services, SAMHSA.

Advance Planning	**Family members may need assistance with child care, transportation, etc. in order to participate in meetings/activities.**	Many family members may lose time at their jobs or with their families in order to partner. Honoraria should be considered in appreciation for their time and involvement.
Initial Meetings	**Family members need the opportunity to meet, greet, and relax in an informal setting before the initial meeting begins.**	It is important that family members feel welcome and comfortable in a new setting. Having more than one family member in any one session supports a family member's comfort level; the weight of responsibility for representing "all" families is too overwhelming for one person to carry alone.
Initial Meetings	**Take as much time as needed to allow family members to tell their stories in an unrushed way during introductions.**	In an initial meeting, sufficient time should be built in for the family members to tell their stories; this is an opportunity for collaborative/service delivery members to gain information about gaps, barriers, and successes.
Initial Meetings	**By working together outside of the service delivery setting, providers can "demystify" themselves in the eyes of family members, and they will see family members as more than "consumers."**	In partnership building settings, such as collaborative meetings, serious work is combined with socializing, which lets family members and providers see each other as whole persons; continued interaction in diverse settings helps build the family-provider relationship that ultimately results in improved outcomes for both the family and the provider.
Initial Meetings	**Family members need frequent scheduled breaks to stay productively engaged in group work.**	Meetings should have scheduled breaks at least every 1 ½ hours to allow family members (as well as all participants) time to make phone calls, or just get away from the intensity of discussions.
Long-term	**Sustained motivation to participate in organizational activities and group meetings is derived from the desire to make a contribution, as well as the desire to gain new knowledge and expertise that will be personally beneficial and valuable to other family members.**	In recruiting family members, orientation to the mission and nature of the meetings is essential to engage their interest and to allow them to prepare themselves to make a meaningful contribution. Equally important is feedback to family participants so they will know their involvement is valued. Organizations should identify ways to acknowledge the contributions of family members and incorporate these practices within the norms of the organization.

Long-term	**Providers and others should make every effort to convey information in child-first language and to eliminate the use of acronyms and abbreviations.**	Child-first language speaks to the inclusion of children within the community, for example: speak of "children whose environment puts them at risk for problems" rather than "at-risk children". Acronyms create a "club house" mentality – families feel outside the club.
Long-term	**Collaboratives/organizations should model a strengths-based style and philosophy that shifts the mode of thinking and operating away from the deficit model.**	Family-centered care emphasizes a philosophical shift from deficits to strengths, from control to collaboration, from an expert knows all model to a partnership model, from dependence to empowerment.

What does Family Partnership Look Like in Practice?

- Agency professionals communicate and share complete information with families in a manner that is practical, non-blaming, affirming, and constructive
- Communication and planning emphasize the strengths and assets of families, their neighborhoods, and communities to promote competency and independence
- Family members of children and youth receiving services are included at the service, program, and system levels
- Services are family-centered and assist families in their natural role as the primary caretakers of their children by acknowledging and respecting them as experts regarding their own children's strengths, needs, and progress
- Agency and organization structures promote inclusion of family members and appreciate the family's unique value as key informants and full partners in program/system design and improvement, and provide the resources and knowledge that can benefit the family, programs, and systems

Successful family partnership reforms the system positively by:

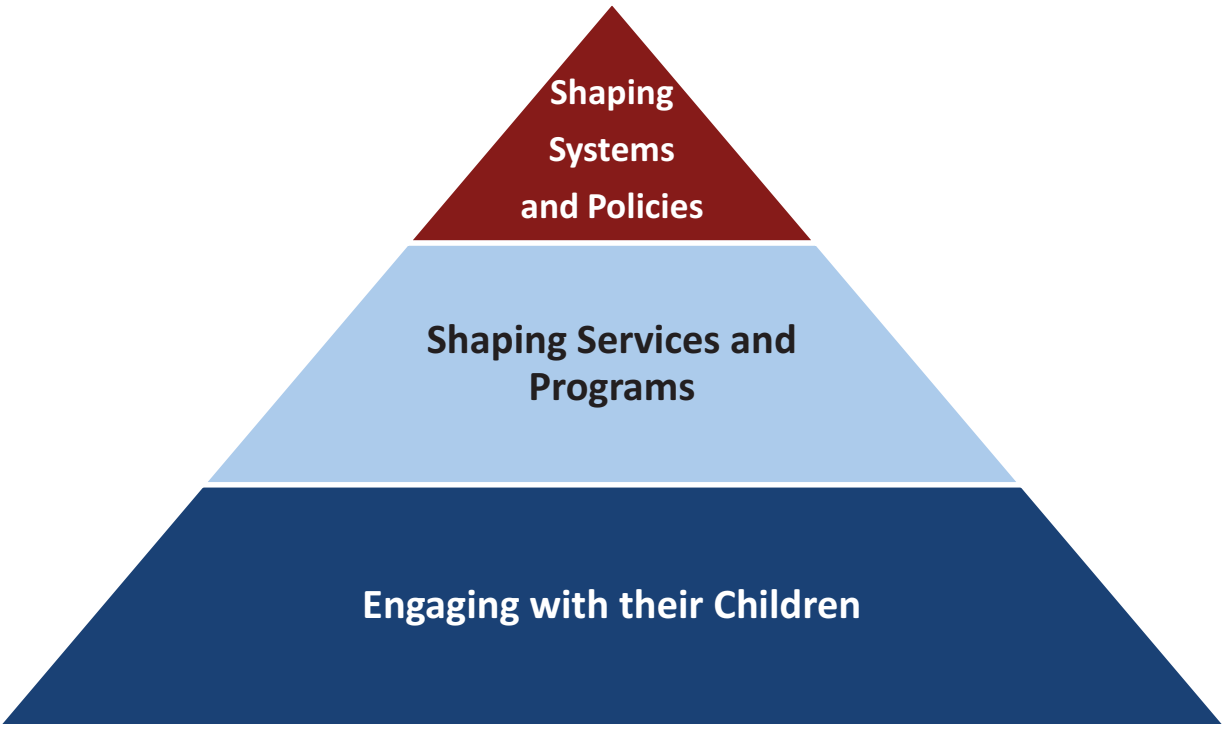
- Acknowledging and promoting family members as the most vital participants in the process
- Increasing family capacity to meet the needs of their child, resulting in improved outcomes and achievements

When family members are actively engaged in ongoing dialogue and decisions at all levels, including advisory, training, program design and implementation, service delivery, and evaluation, they can improve the system by holding it accountable and keeping the cross-agency focus on children, youth,

and their families, while they improve their own abilities to resolve problems and support family members.[49]

How to Engage Families

Because a child's well being is deeply rooted in the environment that the family creates, engaging family members as active partners with service planners and providers is essential. However, often those families most in need of services are least likely to engage in them. Consequently, developing and implementing strategies to engage families becomes critical work for the collaborative and service delivery systems.



A Three-Part Framework for Engaging Parents in Supporting Healthy Child Development[50]

Level 1 – Engaging with their children

Parents should be supported in their parenting role and opportunities should be created for them to be involved in decisions about their child's health and development. Parents can be supported in a number of functions including:

[49] Osher, T., deFur, E., Nava, C., Spencer, S. and Toth-Dennis, D. (1999). New roles for families in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume I.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

[50] Ahsan, N. and Rosenthal, J. (2010). *Engaging parents as partners to support early child health and development.* Portland, ME: National Academy for State Health Policy.

- Involvement in decision-making about their child's health, such as choosing and accessing services, expressing needs during care visits
- Engagement in activities that help promote child development, such as reading and playing with their child, preparing healthy meals, modeling positive behaviors
- Knowledge and awareness of their child's needs, that is understanding developmental benchmarks, physical and emotional conditions
- Understanding their ability to influence and promote their child's health and development

Level 2 – Shaping services and programs

Parents should be encouraged to actively participate in the programs that serve them and their children. In addition to being engaged with their service provider, they may belong to the larger community within the program by:

- Participating in social events and other activities that bring together program participants
- Participating in advisory boards or other decision-making structures within the program
- Helping advocate for the program
- Mentoring or providing support to other program participants

Level 3 – Shaping policies and systems

Parents are asked to extend their involvement beyond their own personal experience to represent the interests of a broader constituency, thus informing and shaping policy improvements relevant to the larger population of focus by:

- Serving on a community collaborative representing family voice
- Serving on task forces, evaluation workgroups, etc.

The pyramid does not represent three alternate strategies, but rather a dynamic structure in which three types of partnership support and inform each other. Engaging the families, who are most affected by decision-making about policies and systems, ensures that services and systems are responsive to the needs of families and structured in a way that truly supports families. Family involvement at all levels helps identify barriers and strategies, resulting in overall system improvements.

Understanding the many issues that support or derail families' engagement in services is a necessary foundation for successful engagement interventions. Engagement strategies must respond to these factors while helping families connect with needed supports and services. Kemp and others propose six overlapping engagement strategies to facilitate family involvement in treatment services.

Section 4 FAMILY AND YOUTH PARTNERSHIP AND ENGAGEMENT

A Typology of Family Engagement[51]

Early outreach and responsiveness to parents' identified needs and priorities	Initial contacts should be early, active, and persistent; they provide key opportunities for staff to acknowledge, validate, and respond to parents' most pressing needs. Brief, structured interventions significantly improve the likelihood that families will initiate and sustain involvement.
Practical help	Responding to immediate, practical needs is central to successful engagement. Participation is enhanced by the provision of a wide array of concrete services, such as transportation, appointment scheduling that is responsive to family situations, etc.
Parent education and empowerment	Informed parents who are educated about what they can expect, and about their own and others' roles and responsibilities are more likely to engage and stay involved in services. Parents identify system navigation skills as a pressing need, including the ability to communicate effectively, knowledge of institutional policies and practices, skills in managing negative and conflicted emotions to avoid negative judgments by agency staffs, skills in researching needed resources and services, and problem solving skills.
Supportive, respectful, culturally relevant and available relationships with service delivery staff	Families value honest, direct, helpful, empathetic communication by workers – they want to know where they stand and what is expected of them, but also want to feel "seen and heard."
Consultation and inclusion in planning, decision-making, and service provision	Successful partnership rests on collaborative treatment planning. When parents actively participate in, and agree to a plan, they tend to comply more fully.
Policy, organizational and administrative practice that supports inclusive, family-centered, and culturally responsive practice	Worker, organizational, and policy factors interactively influence efforts to engage families. The more time workers and families spend in direct contact, the higher the degree of engagement and collaboration. Organizational priorities shape the time and attention that service delivery staff allocate to parents. Worker attitudes also influence engagement; a deficit orientation results in lower levels of family engagement.

[51] Kemp, S, Marcenko, M., Hoagwood, K. and Vesneski, W. (2009). *Engaging parents in child welfare services: Bridging family needs and child welfare mandates.* Child Welfare. Accessed at http://findarticles.com.

Section 4 FAMILY AND YOUTH PARTNERSHIP AND ENGAGEMENT

How to Engage Youth

Increasingly, systems of care have adopted the concept of a youth-guided system when the population of focus is adolescents. Principles of a youth-guided system include the following:

- Youth have rights
- Youth are utilized as resources
- Youth have an equal voice and are engaged in developing and sustaining the policies and systems that serve and support them
- Youth are active partners in creating their individual service plans
- Youth have access to pertinent information
- Youth are valued as experts in system transformation
- Youth's strengths and interests are focused on and utilized
- Adults and youth respect and value youth culture and all forms of diversity
- Youth are supported in a way that is developmentally targeted to their individual needs[52]

As with other family members, it is important that youth have defined roles in the system of care, for example:

- Create youth advisory boards
- Develop youth run organizations
- Train and utilize youth as peer mentors
- Involve youth as trainers and evaluators

What is Family-Driven Care? [53]

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community. This includes:

- Choosing culturally and linguistically competent supports, services, and providers
- Setting goals
- Designing, implementing and evaluating programs
- Monitoring outcomes
- Partnering in funding decisions.

Guiding Principles of Family-Driven Care

- Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes.

[52] Pires (2008)
[53] National Federation of Families. Accessed at http://www.ffcmh.org/r2/publications2/family-driven-defined/

- Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families.
- All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time.
- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven.
- Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families and where family and youth run organizations are funded and sustained.
- Community attitude change efforts focus on removing barriers and discrimination created by stigma.
- Communities and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of the diverse populations are appropriately addressed.

Assessing the System and Family Partnership

	Conventional System	Cooperative System	Collaborative System
SYSTEM	*Families are viewed as agency obligations and recipients of services *Resource distribution and policies center around agency mandates and specializations	*Policy makers may include families as guests or as participants in focus groups *The opinions of families are solicited as representatives of a consumer group to be considered in governance, resource, and policy decisions.	*Policy makers view family members as partners in governance, resource, and policy decisions *Decisions are not made without meaningful family participation *Procedures to ensure family inclusion in system, program, and practice levels are implemented *Resource distribution and policies promote a flexible community of families and providers to achieve common goals.

Section 4 FAMILY AND YOUTH PARTNERSHIP AND ENGAGEMENT

	Conventional System	Cooperative System	Collaborative System
PROGRAM	*Agency/organization program managers view families as clients or recipients of services *Resource decisions consider the number of families projected to need certain service slots within confines of agency mandates and resources	*Agency/organization program managers may include families as guests in governance groups, or participants in focus groups to assess client satisfaction and needs *Resource decisions consider the number of families projected to be 'shared' as common clients across agencies	*Agency/organization program managers view families as valued experts in their own right, as partners who possess resources, community information and influence *Family inclusion in planning, management, and evaluation decisions is "a given", efforts to ensure participation are a priority *Resource distribution is planned, implemented and assessed by community collaboratives, measured by outcomes of common goals
PRACTICE	*Families must seek services within confines of each agency/organization *Services are generally one size fits all, according to the agency/organization's mandates *Services are designed, delivered, and evaluated by providers	*Families receive case management/coordination to assist access to services across agencies/organizations *Services are designed and delivered by providers with some modification to meet unique family needs *Family input in evaluation of services is sought	* Service planning and implementation is driven by family strengths and needs, reflecting family context and culture *Services are broadened to incorporate wraparound approaches to fill service gaps according to unique family strengths and needs. *Families are full partners in the design, delivery, and evaluation of services

[54]

[54] Kaufman, M.C. and Tonker, W.L. (2008) The Durham Center for Durham System of Care. Durham, N.C.

Section 4 FAMILY AND YOUTH PARTNERSHIP AND ENGAGEMENT

Helpful Information Resources

Georgia Family Connection Partnership Self-Assessment Tool for Family and Youth Engagement is included in the Appendices.

www.ohsu.edu/cdrc/occyshn//ccntoolbox/documents/FamilyCenteredCare/FURTHER%20EXPLORATION/PartnerSelfAssessmentTool.pdf - Family-Professional Partnership Self-Assessment , a self assessment tool to assist professionals in identifying barriers to their ability to effectively partner with families

www.ffcmh.org – Website for the National Federation of Families for Children's Mental Health, including tool kits for family-run organizations, parent-partner assessments

www.familyvoices.org/info/ncfpp/family_participation.php - resources for partnering with families, links to Family-to-Family Health Information Centers

www.NCTSN.org – website for the National Child Traumatic Stress Network; policy brief on Family, Youth, and Consumer Involvement

www.rhyttac.ou.edu/images/stories/PYD/resources/PYD%20toolkit%202008.pdf - Tool kit for positive youth development, engaging youth in program development, design, and implementation of service delivery

www.iel.org – website for Institute for Educational Leadership (IEL), Tool kit number 3: Family Centered, Culturally Competent Partnerships

www.theinnovationcenter.org – website for The Innovation Center for Community and Youth Development, tools for engaging youth and adults to build stronger communities

The *"Family and Youth Engagement Tool"* located in Appendix D was developed by Georgia Family Connection Partnership to guide community groups in engaging families and youth in meaningful community dialogue.

Section 5 CULTURAL AND LINGUISTIC COMPETENCY

What is Culture?

Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups.

What is Cultural and Linguistic Competency?

Competence implies having the capacity or ability to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by families and their communities. Cultural competence within systems of care is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. [64]

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence requires organizational and provider capacity to respond effectively to the health and well-being literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.[65]

Because social work and health care are cultural constructs, arising from beliefs about the nature of behaviors, disease, and the human body, cultural issues are central in the delivery of services and preventive interventions. In understanding, valuing, and incorporating the cultural differences of the state's diverse population and examining one's own social and health-related values and beliefs, child and family serving organizations can serve a system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.[66]

Culture is important because it affects:

- Attitudes and beliefs about services
- Parenting and child rearing
- Expression of symptoms
- Coping strategies
- Help seeking behaviors as well as helping behaviors
- Utilization of services and social supports, including kinship support
- Appropriateness of services and supports[67]

[64] Office of Minority Health. (2010). *What is cultural competency?* Accessed at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11
[65] Pires (2008).
[66] Office of Minority Health
[67] Pires (2008).

Section 5 CULTURAL AND LINGUISTIC COMPETENCY

Why do System Builders Need to Develop Multicultural Knowledge and Skills?

- To respond to demographic changes in the state
- To eliminate disparities and disproportionality
- To improve the quality and relevance of services and supports
- To meet legislative, regulatory and accreditation mandates
- To decrease the likelihood of class action suits
- To meet federal grant requirements[68]

Given the extent of over-representation of racially and ethnically diverse children and families in the child welfare and juvenile justice systems, and in special education and school disciplinary actions, it is critically important to pay attention to cultural and linguistic competence in all areas of system building – membership of the collaborative/advisory board, planning, service delivery, and evaluation.

What is Disproportionality?

Disproportionality refers to the over- or under-representation of a given population group, often defined by racial and ethnic backgrounds, but also defined by socio-economic status, national origin, English proficiency, gender, and sexual orientation, in a specific population category such as child welfare, juvenile justice, and special education. For example, a child's race and ethnicity significantly influence the child's probability of being misidentified, misclassified, and inappropriately placed in special education programs.[69]

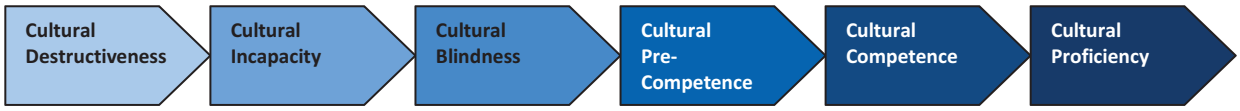
Variables such as language, poverty, assessment practices, systemic issues, and professional development opportunities for staff have been cited as factors that play a role in disproportionate representation.

[68] Pires (2008).
[69] Elementary and Middle Schools Technical Assistance Center. (2010). *Disproportionality.* Accessed at www.emstac.org/registered/topics/disproportionality/faqs.htm

Section 5 CULTURAL AND LINGUISTIC COMPETENCY

Cultural Competence

Cultural competence is a developmental process that evolves over an extended period of time. Individuals and organizations are at various levels of awareness, knowledge and skills along a continuum.



Cultural competence involves a range of behaviors that span from cultural destructiveness to cultural proficiency. Individuals and organizations may go back and forth along this continuum as they endeavor to become more culturally competent. Three elements appear to be essential:

- Respect, honor and the ability to reflect awareness of the diversity of populations with which the system/individual is working
- An acknowledgement of variations in acceptable behaviors, beliefs, and values in assessing and treating a person's problems
- The knowledge, skills, and attitudes to work within the families' values and reality conditions[70]

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively across cultures
- Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery, and involve families and children receiving services, key stakeholders, and communities[71]

Core Elements of a Culturally and Linguistically Competent System of Care[72]

- Commitment from top leadership
- Organizational self-assessment
- Needs assessment and data collection relevant to diverse populations
- Identification and involvement of key diverse community members
- Mission statements, definitions, policies and procedures reflecting the value of cultural and linguistic competence

[70] Institute for Educational Leadership
[71] Pires (2008).
[72] Pires (2008)

Section 5 CULTURAL AND LINGUISTIC COMPETENCY

- Objectives for cultural and linguistic competence in the strategic plan
- Recruitment and retention of diverse collaborative members and staff
- Training and skill development in cultural and linguistic competence
- Targeted service delivery strategies
- Internal capacity to monitor the cultural and linguistic competence implementation process
- Evaluation activities that provide ongoing feedback about process, needs, modifications, and next steps
- Commitment of resources (human and financial) to cultural and linguistic competence quality improvement

Checklist to Facilitate Cultural Competence in Community Engagement[73]

Does the organization have:

- ✓ A mission that values communities as essential allies in achieving its overall goals?
- ✓ Policy and structures that delineate community and family participation in planning, implementing, and evaluating the delivery of services and supports?
- ✓ Policy that facilitates employment and the exchange of goods and services from local communities?
- ✓ Policy and structures that provide a mechanism for the provision of fiscal resources and in-kind contributions to community partners, agencies, and organizations?
- ✓ Position descriptions and personnel performance measures that include areas of knowledge and skill sets related to community engagement and cultural and linguistic competency?
- ✓ Policy, structures, and resources for in-service training, continuing education and professional development that increase capacity for collaboration and partnerships within culturally and linguistically diverse communities?
- ✓ Policy that supports the use of diverse communication modalities and technologies for sharing information with communities?
- ✓ Policy and structures to periodically review current and emergent demographic trends to:
  - Determine whether community partners are representative of the diverse population in the service area?
  - Identify new collaborators and potential opportunities for community engagement?
- ✓ Policy, structures, and resources to support community engagement in languages other than English?

[73] Goode, T. (2001). Policy brief 4: Engaging communities to realize the vision of one hundred percent access and zero health disparities: a culturally competent approach. Washington DC: National Center for Cultural Competence, Georgetown University Child Development Center

Section 5 CULTURAL AND LINGUISTIC COMPETENCY

Qualities of Culturally Competent Human Service Professionals[74]

They seek to learn as much as possible about a child's or family's culture, also understanding the influence of their own cultural background on their responses and actions

They seek out neighborhood and community involvement, including community cultural leaders

They work in the sphere of the child's family configuration, including grandparents, relatives, and friends

They acknowledge, accept, and, when possible, incorporate the role of natural helpers from the family's culture

They endeavor to understand the diverse expectations families may have about the manner in which services are offered, for example: eating together may be an important element of services provided in the home, a social exchange may be considered unnecessary before each contact, entrée to a family may be accessed only through an elder

They understand that tangible services, such as helping in obtaining clothing, housing, and transportation may be needed and expected: they work with community agencies to help ensure that such resources are made available

They work within traditions relating to gender and age that may be important in particular cultures, for example in some ethnic groups, elders are highly respected

Becoming culturally competent is a process that must begin with an honest assessment of each individual's beliefs and actions as it relates to diversity; individuals often believe they are culturally competent without thoroughly examining their own values and behaviors.[75] The Colorado Department of Human Services developed the following set of questions to assist individuals in self-assessment:

1. How much personal/social time do I spend with people who are culturally similar to, or different from me?
2. When I am with culturally different people, do I reflect my own cultural preferences or do I spend the time openly learning about the unique aspects of another person's culture?
3. How comfortable am I in immersion experiences, especially when I am in a numerical minority? What feelings and behaviors do I experience or exhibit in this situation?
4. How much time do I spend engaged in cross-cultural professional exchanges? Is this time spent in superficial, cordial activity, or do I undertake the risk of engaging in serious discourse that may divulge my fears and lack of knowledge?

[74] Institute for Educational Leadership
[75] Kaufman, M.C. and Tonker, W.L. (2008)

5. How much work have I actually done to increase my knowledge and understanding of culturally and ethnically distinct groups? Does this work include only an occasional workshop in which I am required to participate? What are my deficiencies and gaps in knowledge about important cultural issues?
6. What is my commitment to becoming culturally competent? What personal and professional sacrifices am I willing to make in the short term for the long term benefit of all children and families?
7. To what extent have I non-defensively extended myself in approaching professional colleagues with the goal of bridging cultural differences?
8. Am I willing to discontinue representing myself as knowledgeable and as having expertise in areas of cultural diversity that I have not actually achieved?
9. If I am unwilling to commit to a path leading to cultural competence, will I take the moral and ethical high ground and discontinue providing services to people I am unwilling to learn about?[76]

Establishing and sustaining broad-based community partnerships through a system of care approach presents many benefits while simultaneously presenting unique challenges. One of the most fundamental challenges involves the complex nature of communities and the growing diversity within many of Georgia's communities. Factors impacting community diversity involve more than race and ethnicity; other factors include, but are not limited to, geographic location, population density, population stability, age distribution, socio-economic status, religious or spiritual beliefs, and health beliefs and practices. Understanding of these factors and respect for their relevance are necessary for effective community engagement.[77]

[76] Cultural Competence in Child Welfare: What Is it? A Cultural Competence Attainment Model, Colorado Department of Human Services. http://www.cdhs.state.co.us/cyf/cwelfare
[77] Goode, T. (2001).

Section 5 CULTURAL AND LINGUISTIC COMPETENCY

Helpful Information Resources

http://nccc.georgetown.edu/foundations/assessment.html - website for National Center for Cultural Competence, tools and processes for self-assessment at the individual and organizational levels.

www.iel.org – website for the Institute for Educational Leadership, Systems Improvement, Training and Technical Assistance Project, Tool Kit Number 3 – Family-Centered, Culturally Competent Partnerships

http://www.doe.k12.ga.us/ci_exceptional.aspx?PageReq=CIEXCDispro – website for the Georgia Department of Education, information on Disproportionality

http://www.emstac.org/registered/topics/disproportionality/faqs.htm - website for Elementary and Middle Schools Technical Assistance Center, Frequently Asked Questions regarding disproportionality

http://www.tapartnership.org/COP/CLC/implementationGuide.php - Link to the Cultural and Linguistic Competence Implementation Guide January 2008, developed by the Technical Assistance Partnership for Child and Family Mental Health. The guide is an exhaustive reference for implementing cultural and linguistic competence across the domains of governance and organizational infrastructure, services and supports, planning and continuous quality improvement, collaboration, communication, and workforce.

Section 6 SERVICE DELIVERY

What is Service Delivery?

Service delivery within systems of care is a coordinated, integrated and continuous process whereby children and families are linked with the services they need to achieve desired outcomes. A collaborative service delivery system is a result of the set of system of care principles and values, and the collaborative mission and vision guiding the design, development, implementation, and operation of services delivered by service providers. Service delivery encompasses:

- Outreach and Referral Process
- Screening, Assessment, and Evaluation
- Service Planning
  - Coordination and Service Plan Development
  - Strength-based and Culturally Relevant
  - The Service Plan
  - Evidence-Based Practices
- Utilization Management
- Engagement and Retention of Families in Service Delivery

The functions listed above may be carried out by different entities, but they must be linked in a seamless process and by a practice model that reflects system of care values. Service planning is individualized and done in partnership with families, and youth when appropriate; it is family-centered and family-driven.

What is Family-Centered Care?

Family-centered care supports all family members involved in the child's/youth's care and involves family members in all aspects of planning, implementing, and evaluating the service delivery system. Practicing family-centered care results in moving the focus of service professionals:

- from family deficits to family strengths
- from control to collaboration
- from "expert" model to partnership
- from information gate-keeping to information sharing
- from negative expectations to positive support
- from rigidity to flexibility
- from child/family dependence to child/family empowerment.[92]

Outreach

One of the goals of systems of care is to improve access to appropriate services and supports for children and their families within the population of focus. Outreach and referral processes must be structured in a manner that ensures access to services for the specific population.

Outreach strategies and activities must be tailored to the population of focus; for example, if a targeted concern is the over-representation of African American children and families involved or at risk of

[92] Kaufman, M.C. and Tonker, W.L. (2008).

involvement in child welfare, strategies need to be developed to reach out to, and engage, the African American community itself, as well as those people who make decisions about referring children into child welfare. If the population of focus is youth in transition, strategies are needed to reach out and engage the youth themselves, as well as appropriate community resources such as housing agencies, employment agencies, higher education, etc.[93]

Families, and youth when appropriate, can play important roles in outreach, such as: family peers can be available at points of entry into systems, such as child protective services office, courts, schools; families can help build environments of trust, such as focus groups, education forums, and support groups.

Outreach strategies may include: brochures in English, as well as any other identified language for the population of focus; community presentations at schools, faith-based communities, civic groups, etc; development of websites; community forums.

Referral Process

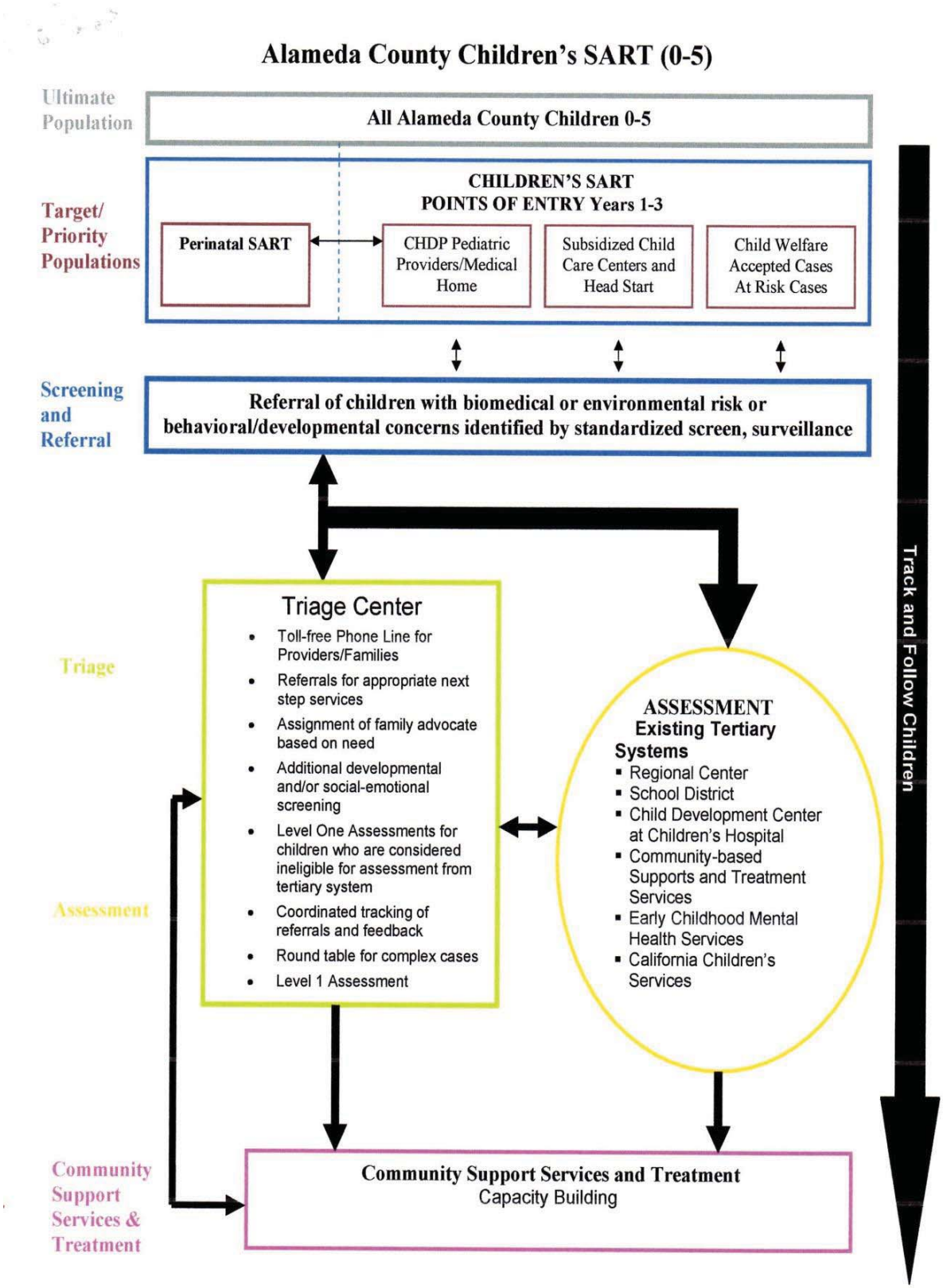
Structuring the referral process is an important issue that must be given thoughtful attention as it has significant implications for capacity, or lack thereof. The difference between a limited referral base in which, for example, only partner agencies can refer, and an open referral process in which anyone can refer, including families self-referring, will have implications for managing access and services.

There is no one correct process for structuring referrals - the structure depends on such factors as service capacity, available resources, the extent of demand, community political implication, etc. What is important is for such factors to be analyzed, recognizing the pros and cons of whatever referral structure is established and the ability to communicate to stakeholders and the community at large the rationale for the structure that is put into place.

It can be helpful to create a flow chart, a visible description of the referral process. For example, below is a flow chart describing the referral process for the Alameda County, California Screening, Assessment, Referral and Treatment (SART) Program. [94] While the collaborative acknowledged the need for a system that would meet the needs of all children in the county, it was agreed to begin with the highest risk population of children ages 0-5 years who: are in the child welfare system, are receiving primary medical care from a specific provider, are enrolled in state subsidized preschool or Head Start, and were exposed to substance use prenatally.

[93] Pires. (2008)

[94] Rane, K., Ogilvie, R., Moonka, N., Susskind, J. and Bennett, P. (2007). *Alameda County Children's SART Strategic Plan for children 0-5.*


Alameda County Children's SART (0-5)
Ultimate Population
All Alameda County Children 0-5
Target/ Priority Populations
CHILDREN'S SART
POINTS OF ENTRY Years 1-3
Perinatal SART
CHDP Pediatric Providers/Medical Home
Subsidized Child Care Centers and Head Start
Child Welfare Accepted Cases At Risk Cases
Screening and Referral
Referral of children with biomedical or environmental risk or behavioral/developmental concerns identified by standardized screen, surveillance
Triage
Triage Center
Toll-free Phone Line for Providers/Families
Referrals for appropriate next step services
Assignment of family advocate based on need
Additional developmental and/or social-emotional screening
Level One Assessments for children who are considered ineligible for assessment from tertiary system
Coordinated tracking of referrals and feedback
Round table for complex cases
Level 1 Assessment
Assessment
ASSESSMENT
Existing Tertiary Systems
Regional Center
School District
Child Development Center at Children's Hospital
Community-based Supports and Treatment Services
Early Childhood Mental Health Services
California Children's Services
Track and Follow Children
Community Support Services & Treatment
Community Support Services and Treatment
Capacity Building

Questions to consider in designing the referral process:

- Who can be referred?
- How are they referred?
- What is the referral process?
- How long does the referral process take?
- What happens if a referred child is not accepted?

Screening, Assessment, and Evaluation

Screening, assessment, and evaluation are three separate functions that are closely linked, one building on the other to provide information regarding the strengths and needs of individual children and their families.

The intention of *screening* is early identification, enabling early intervention. Universal screening involves screening all individuals within a certain category (for example all children of a certain age). Case finding involves screening a smaller group of individuals based on the presence of risk factors; it is this type of screening that is most prevalent in systems of care. The concept of early intervention is one of the basic tenets of systems of care for children and adolescents of all ages.

Assessment is a process of gathering information from multiple sources to create a comprehensive "picture" of children who need services, with the purpose of identifying strengths and needs in order to develop a plan for specific services and supports.

Evaluation is often discipline-specific, for example a psychological evaluation, a hearing evaluation, etc, and is conducted by individuals trained and/or certified in the specific discipline. Evaluations provide more in-depth information in a particular area to assist in the care-planning process.

Traditional Screening, Assessment & Evaluation	Systems of Care Screening, Assessment & Evaluation
Needs driven	Strengths and resource driven
Specific to the child only	Take into account both child and family
Multiple assessments conducted by multiple child-serving systems	One coordinated assessment across child-serving systems
Often discipline specific based on most problematic issue	Comprehensive across life domains and culturally appropriate; life domains include: emotional, spiritual, cultural/ethnic, safety, medical, educational, social, family, residential, legal, and economics (income)

System of care screening, assessment, and evaluation are not "done to" children and families, but *with* them as equal partners who have a lot of knowledge to contribute to an analysis of the issues in their lives and potential strategies for addressing them.[95]

[95] Pires. (2008)

Section 6 SERVICE DELIVERY

Systems of care builders cannot assume that clinicians and others involved in screening, assessment, and evaluation processes know how to conduct strengths-based assessments that are culturally competent, or that they know how to engage families in partnership in the screening, assessment, and evaluation processes.

Protocols or Memoranda of Agreements must be structured to ensure a coordinated screening, assessment, and evaluation process that respects culture and family partnership.

Service Planning

KEY ELEMENTS OF SERVICE PLANNING

- ***Services are coordinated*** across the public and private child-serving systems to provide the most comprehensive and all-inclusive package of services to meet the specific developmental, emotional, behavioral, social, educational, medical, mental health, and substance abuse needs of children, youth, and families
- School systems are involved in case planning and service delivery
- Natural support networks are part of multi-disciplinary case planning teams working with children and families
- Service coordination takes into account the child's and family's needs, providing only those services responsive to the child's and family's identified strengths, needs, wants, and goals
- Agencies do not overwhelm the child or family with multiple, simultaneous requirements
- Agencies work together to ensure the child and family do not hear inconsistent messages or receive contradictory or incompatible services or treatment
- Agencies respectfully and appropriately share information so that children and families do not have to repeat their stories
- In sharing information, confidentiality requirements are understood and adhered to
- Coordination efforts take into account agency mandates
- ***Services are culturally competent and relevant and aligned with the child's and family's cultural strengths and values***
- ***The child/youth is viewed in a holistic way in the context of his/her developmental needs***

KEY ELEMENTS OF SERVICE PLANNING

- ***Natural supports*** (friends, relatives, faith-communities, community groups, etc.) ***are considered to be as essential*** as professional and agency services
- Service planning identifies ***protective factors*** and build on the child's and family's strengths while addressing ***relevant risk factors***
- The service array spans the spectrum from prevention and early intervention, community-based services to more intensive services, such as residential
- A strong aftercare system for children and youth leaving any of the child-serving systems ensures their ability to succeed
- ***Programs and services are evidence-based***
- Service planning is ***individualized and directed by the child's or family's life goals, desires, values, and plans***
- ***One service plan*** includes all the services the child and family will receive from any child-serving system, and it reflects the input of all relevant systems and professionals
- Service planning focuses on providing services and supports for the child and family at the appropriate level and intensity and in the ***least restrictive, intrusive environment*** that can increase their stability and well-being
- Services are provided in locations and at times that are convenient for the child and family
- The service plan is reviewed on a regular basis and is updated to reflect the child's and family's progress

The above key elements were developed by a diverse group brought together as experts in designing and delivering services to children, youth, and families. The group represented various communities from all over the country, and included family members with children currently in child-serving systems; administrators of child-serving systems including child welfare, juvenile justice, and education; and private sector agencies.[96]

[96] Hornberger, S., Martin, T., and Collins, J. (2006)

Coordination and service plan development

Service coordination or care management is a foundation of service delivery in systems of care; it is a set of activities which assures that each child and family served in the system has a single approved care/service plan that is coordinated across agencies and providers, not duplicative, and designed to be cost effective and result in positive outcomes. Care managers oversee and monitor the progress of the child and family in achieving care plan objectives, assist the family and child in linking with the services needed to achieve the objectives, and update the plan as needed.

The structure of care management/service coordination is dependent upon the population of focus and the goals of the system of care. For instance, prevention and early intervention activities will allow for larger case loads, while a population of focus requiring intensive level of services and supports will require very small caseloads.

Functions of service/care coordination:

- Single locus of accountability
- Development of single plan of care, and crisis/safety plans that are family-driven, youth-guided (as appropriate), cross-agency, strengths-based, and culturally relevant
- Assisting family with linking to service providers and natural supports of their choice

Service plans (or plans of care) must include information required to satisfy the goals and mandates of each of the child-serving agencies involved with the family, but they cannot be simply a compilation of separate pieces of plans or information made available by each agency. Individual agency goals, mandates, and services should be integrated into a single and comprehensive statement of services that is clear to families and service providers. The collaborative Advisory Board can be instrumental in directing agencies to work together toward developing unified service plans.

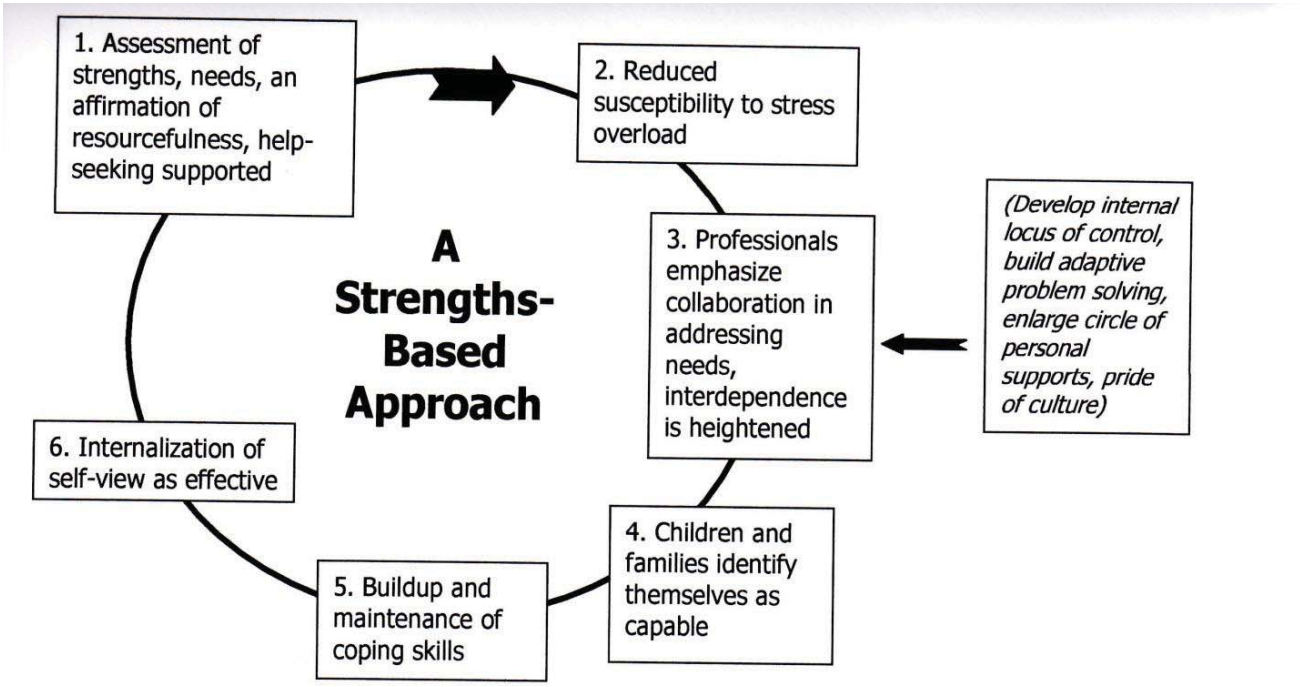
Strength-based and culturally relevant

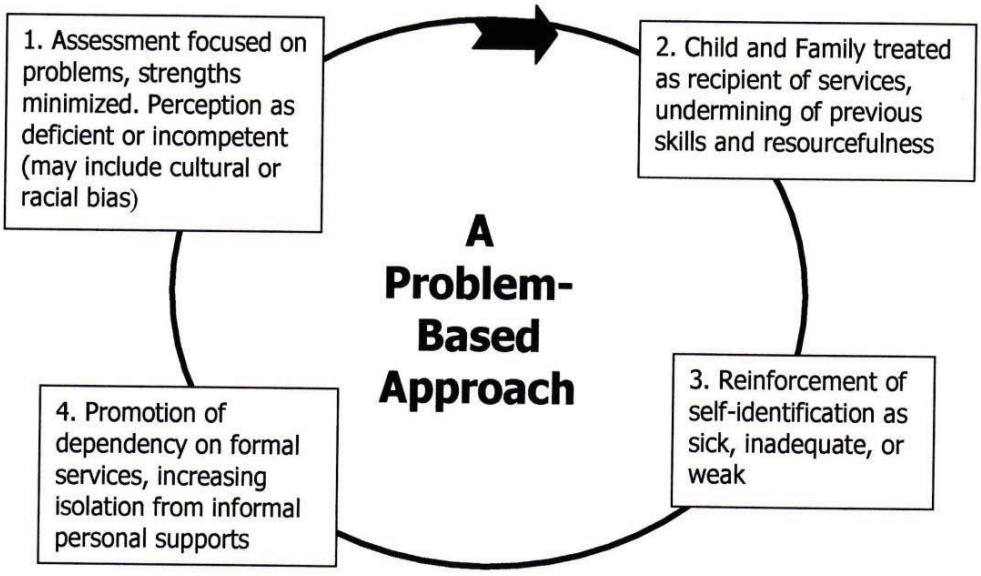
"Presuming the positive" is an important part of a strengths-based approach. This concept has two parts:

- The presumption of competence and good intentions on the part of family; and
- The postponement of immediate judgment or, offering the "benefit of the doubt" on the part of staff[97]

Solutions to complex family issues will require effective collaboration between professionals, system of care staffs, and family members, and respect for the expertise that each brings to the work. Research indicates that strengths-based approaches result in better outcomes than approaches that are problem or deficit based.

[97] Hodas, G. (2001). Presuming the positive as part of strengths-based treatment in working with children and families. *Sharing, XVII,* 1 (5).





Adapted from Pires S. (2002) *Building Systems of Care: A Primer* p. 55

Section 6 SERVICE DELIVERY

In below narrative, CFT refers to Child/Family Team, a group that develops/implements the service plan

Strengths-Based Assumptions	Not Strengths-Based Assumptions
Parents are encouraged and supported as partners willing to learn effective strategies to improve the lives of their family members. They participate in the development of plans, evaluations and assessments of their child, monitoring treatment and determining continuing service and support needs.	Parents don't care for their children and lack the skills to understand their child's complex needs. Professionals develop plans for the child/family, evaluations of the child involve the child alone and parents experience themselves as out of the decision-making loop.
The child has opportunities to actively participate and to make meaningful decisions.	The child is seen as incapable of meaningful responsibility, or as intractably resistant, and is not included in decisions
All families need and deserve support; no family exists in isolation. Professionals help link the family to community resources and personal supports, and facilitate referrals as needed.	Children/families become dependent on formal services and professionals to produce change rather than increasing use of normalizing personal supports and community resources.
Commitment to consensus building among key participants is understood as being essential to effective CFT planning and implementation.	Belief that experts alone are best equipped to make clinical decisions and that involvement of others will only hinder the process.
Recognition that every child's community contains valuable resources to be tapped.	Certain communities are seen as entirely negative without counteracting positive resources.
Recognition that the child/family's cultural heritage and practices need to be understood, respected and incorporated in planning and implementation of services and supports.	Belief that "everyone is the same," that good intentions without attention to culture is sufficient, and that CFT Plans do not need to include cultural dimensions.
Appreciation of the fact that every child and family is different. What works for one does not necessarily work for another. There is a commitment to understanding the culture of the child, family, community, and their support systems.	Belief that available services will be enough for families. Belief that understanding of a single dimension(s) is enough – e.g., child has cerebral palsy or is bipolar, etc.
All families have strengths. Information on strengths is obtained and used to help develop individualized strategies.	Belief that some families don't have any strengths, and/or information on child and family strengths is omitted, superficial, or perfunctory.
There are no quick fixes; meaningful change is attainable; problems are barriers to progress, not fixed pathology.	Problems are seen as a result of regression, fixation and pathology. Tendency to shame and blame.
Promotion of positive relationships, not just immediate improvement in behavior.	Focus on behavior alone, without also attending to supporting relationships needed to sustain improvements.

Durham System of Care - Child & Family Team Handbook (2008) – Version 2
Kaufman, M.C. & Tonker, W.L. (2008). The Durham Center for Durham System of Care, Durham, NC

The service plan

Service plans should be based on the information gathered during the screening, assessment, and evaluation processes, and must be individualized, family-driven, strengths-based and culturally relevant. At a minimum, a service plan should include the following:

- Identifying information, including child(ren), family, service coordinator, natural supports
- Child development and behavior, strengths and current functioning level
- Risks or problems to be addressed and needs identified by family
- Family functioning, strengths and capabilities
- Support network - natural helpers such as relatives, friends
- Safety issues and risks – social, environmental, emotional, physical
- Goals
- Objectives and strategies to reach the goals
- Resources to be applied - informal, community, and professional – protective factors
- Persons responsible for actions - such as making referrals, attending treatment sessions
- Timeframes by which certain actions should occur
- Safety plan that includes identification of safety risks, strategies to decrease or eliminate risks, and steps that family members, providers, and others will take to ensure the safety of children
- Crisis plan – agreed upon approaches for handling crises

Successful interventions must both ***reduce risk factors and promote protective factors***. Common risk factors predict diverse problem behaviors. Implementing risk- and protection-focused programs and services can have positive effects on multiple problematic behaviors. For example, early academic failure is a risk for several adolescent problem behaviors – delinquency, substance abuse, teen pregnancy, school drop-out, and violence. [98]

Major Risk Factors[99]

Residential Factors	**Safety Factors**	**Income/Economic Factors**
Homeless	Neighborhood with violence	Poverty
Shelter/temporary housing	School with violent incidents	Low-paying job
Crowded living space	Gang activities	Dependence on welfare
Substandard housing	Inability of family to protect children	Fixed income (SSI)
Housing in high density areas		Lack of steady employment
Geographic isolation		Migrant work

[98] Communities That Care
[99] Pires (2008).

Family Factors
Teenage parents
Single parent household
Family instability
Parental substance abuse
Death of parent/caretaker
Domestic violence
Child abuse/neglect
Parental imprisonment
Marital conflict
Generational conflict
Poor parenting skills

Social Factors
Immigration/migration
Language barriers
Communication barriers
Lack of friends
Dependence on gangs
Lack of community support
Discrimination
Oppression
Lack of meaningful leisure activities

Educational/Vocational
Behind peers in grade level
Poor academic achievement
High school dropout
Illiteracy
Learning disability
Inability to be employed
Lack of access to jobs
Lack of training and skills for job market

Psychological/Emotional
Undiagnosed depression
Exposure to chronic violence
Inability to handle stress
Psychiatric hospitalization
Suicide attempts/completion
Blocking emotional needs
Trauma
Low self-esteem
Behavior mgt. problems

Medical Factors
Lack of access to medical care
Lack of health insurance
Lack of preventive treatment
Terminal disease
Sexually transmitted diseases
Teenage pregnancy

Cultural/Ethnic Factors
Identity confusion
Belief in stereotypes
Low self-esteem based on race or color
Dislike of people of same race or culture

Legal Factors
Violation of civil rights & liberties
Incarceration or detention
Involvement with juvenile justice system
Exposure to police harassment/brutality

Spiritual Factors
Lack of spiritual values
Lack of involvement in church or other rituals
Over-reliance on spiritual life

Protective Factors[100]

Positive peer group
Caring relationship with an adult
Positive self-concept, cultural identity
Participation in religious activities
Strong internal coping mechanisms
Academic success
Participation in sports/group activities
Appreciation of one's racial/cultural group
Supportive family network
Social connections
Ability to express affective emotions in a non-destructive manner

[100] Pires (2008)

What are Evidence-Based Practices?

Evidence-based Practices (EBP) are treatment approaches, interventions and services, that have been researched and shown to make a positive difference in the lives of children, and, at a minimum, the research used both a treatment group and a non-treatment group, and the outcomes for those in the treatment group were better than the outcomes for those who received no treatment.

Evidence-based programs should have fidelity measures – that is, evidence that the program is adhering to key elements of the evidence-based practice shown to be critical to achieving the outcomes found in the research based controlled trial treatment group.

Systems of care strive to utilize evidence-based practices, to the extent possible. Resources identifying evidence-based practice are listed in the Helpful Information Resources section of this document.

Utilization Management

Utilization management is the collection, assessment, and monitoring of information regarding services:

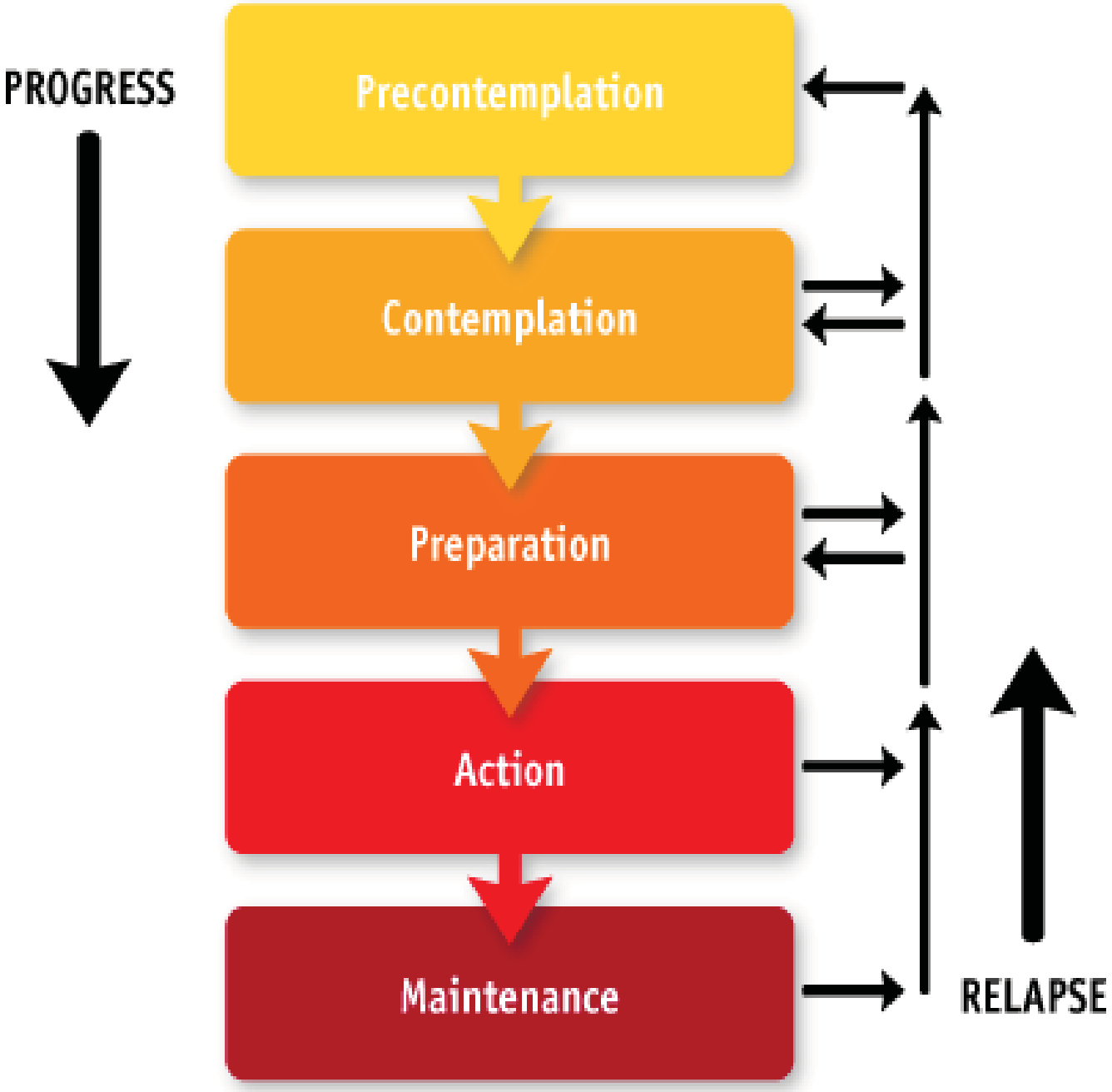
- Who is using services?
- What services are being used?
- How much service is being used?
- What effects are the services having on those using them?
    - Are child/family outcomes improving?
    - Are families and youth satisfied?
- What is the cost of the services being used?

Utilization management helps ensure that children and families are receiving the right service, for the right amount of time, in the right amount, and will help inform decisions regarding when and how children and families exit the system of care.

Engagement and Retention

For services to be effective, families and children/youth must engage in them and continue to attend until they receive maximum benefit. Engaging and retaining families in services can be challenging. It may be useful to think of engagement in terms of the Stages of Change model. First developed in the early 1980s by Prochaska and DiClemente, it has gained wide acceptance by the medical, behavioral health, and social studies fields to explain behavior. Stages of change are:

- Pre-contemplation – individuals are unaware or "under-aware" of their problems
- Contemplation – individuals are aware a problem exists, but have not made a commitment to take action
- Preparation – individuals are intending to take action
- Action – individuals change their behavior or environment in order to overcome their problems
- Maintenance – individuals work to consolidate gains made, and prevent relapse


PROGRESS
Precontemplation
Contemplation
Preparation
Action
Maintenance
RELAPSE

Stages of Change and Engagement Strategies[101]

Stage of Change	Engagement Strategies and Activities
Pre-contemplation 1. Family has no relationship with the system of care 2. Family may not be aware of their service needs 3. Family may be over-whelmed with meeting daily life demands 4. Family may be suspicious of SOC staff intentions and their ability to help 5. Family may not know or understand agency services and mandates 6.	**DO** **1.** Get to know the family and learn about their story **2.** Identify immediate safety and crisis concerns; put together an initial crisis plan to help ensure the family's safety and security **3.** Provide practical assistance to help the family meet immediate needs (food, transportation, etc) **4.** Provide supportive outreach (phone calls, notes, etc) **5.** Educate the family about the System of Care **DO NOT** **1.** Blame/confront the family about their decisions, involvement, etc **2.** Overwhelm or push the family with too much information, paperwork **3.** Stay out of touch **4.** Fail to follow through with plans and agreements
Contemplation/Preparation 1. Relationship with SOC is beginning to develop 2. Basic needs are not constantly disrupting life 3. Family may not fully appreciate how their involvement in the SOC process and in their child's services can make a positive difference	**DO** 1. Check on the safety/crisis plan – is it working? Modify as needed 2. Practice with the family what to do if a crisis occurs 3. Listen and seek understanding of the family's needs and goals. Learn about and record their strengths, abilities, hopes, needs, and culture 4. Listen and seek feedback regarding what is helpful 5. Help the family identify and begin thinking about how to build or rebuild personal supports to help them meet their needs and reach goals 6. Help the family develop the Individualized Service Plan 7. Explain and get all necessary consents/releases of information 8. Continue educating the family about SOC; help the family think about how their involvement can help them reach their goals, achieve stability and hope. 9. Help the family learn more about child development, the impact of risk factors on the family, basic services, self-advocacy, and support **DO NOT** 1. Blame/confront the family about their decisions, involvement, etc. 2. Overwhelm or push the family with too much paperwork or information 3. Allow the family to become too dependent on SOC staff 4. Stay out of touch 5. Fail to follow through with plans and agreements

[101] Kaufman, M.C. and Tonker, W.L. (2008)

Action	**DO**
1. Family begins to see the value of SOC in helping them meet their needs and reach goals 2. Family begins to see they have an essential role in the SOC and in helping their child obtain needed services 3. Family begins to trust SOC 4. Family is willing to consider best practice approaches 5. Family is learning how and beginning to take on more responsibility for meeting their basic needs and advocating for their child and themselves. Family is building personal support networks 6. Family members are open to participating in support groups and in services 7. Family becoming more hopeful that they can reach their goals 8. Family is transitioning to self-support	1. Remember that change is dynamic and happens in stages – recognize the need for, and be prepared to, go back to Pre-contemplation, Contemplation stages, and engagement strategies if the family starts to relapse 2. Check on the safety/crisis plan – is it working? Modify as needed 3. Review/practice with family what to do if a crisis occurs 4. Actively promote involvement in family support and advocacy activities to help the family move toward self-support 5. Support the continued use of the Individualized Service Plan as a guide for the family and a tool for the SOC 6. Encourage and help prepare the family and their personal supports to take on leadership roles in the SOC **DO NOT** 1. Blame/confront the family about their decisions, involvement, etc. 2. Overwhelm or push the family with too much paperwork or information 3. Allow the family to become too dependent on SOC staff 4. Stay out of touch 5. Fail to follow through with plans and agreements

Helpful Information Resources

http://gocfweb.com/bpp/ - Governor's Office for Children and Families Compendium of Best and Promising Practices

www.promisingpractices.net – website for the Promising Practices Network on Children, Families, and Communities; information on programs that work by outcomes (healthy and safe, ready for school, etc); by indicators (such as low birth weight, etc); by topics, and by evidence level. Also includes information on frameworks for service delivery.

www.strengtheningfamilies.org – website for Strengthening America's Families, includes effective programs for delinquency prevention

http://nrepp.samhsa.gov/ViewAll.aspx - website for the National Registry of Evidence-based Programs and Practices for the promotion of mental health and treatment of mental illness, searchable by age, setting, outcomes, gender, race/ethnicity, area of interest

www.childwelfare.gov/can/factors - website for the Child Welfare Information Gateway, information on risk and protective factors for child abuse and neglect

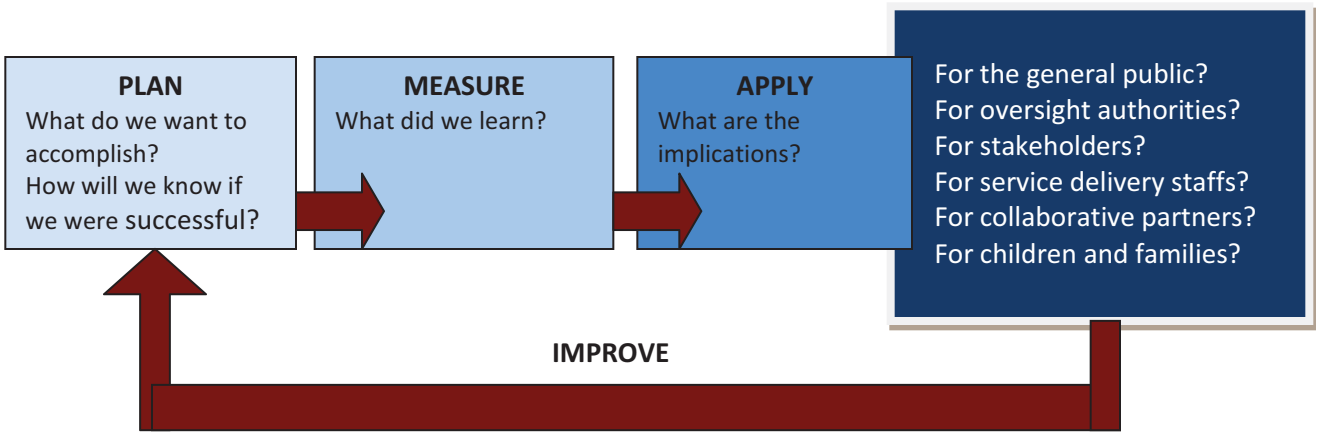
www.sagepub.com/gargiulo3estudy/pdf/Gargiulo_IFSP.pdf - sample individualized service plan

Section 7 ACCOUNTABILITY

What is Accountability?

Accountability is the continual assessment of practice, organizational, and financial outcomes to determine the effectiveness of systems of care in meeting the needs of children and families. Accountability enables stakeholders and funders to ensure that agencies fulfill their responsibilities to those they serve and emphasizes the value of communicating with, and soliciting feedback from stakeholders about system of care activities, expectations, and outcomes.[112]

Phases of Accountability[113]



Planning

Holding systems accountable requires measuring the extent to which they are successful. Measuring success requires the establishment of clear outcomes and a plan for achieving them. Developing a logic model helps the system of care connect its activities to outcomes. The logic model is a vital conceptual tool that links the needs of the children and families, the desired outcomes, the way the system of care will work together to achieve those outcomes, and the methods that will be utilized to find out if the outcomes are being achieved.

What is a logic model?

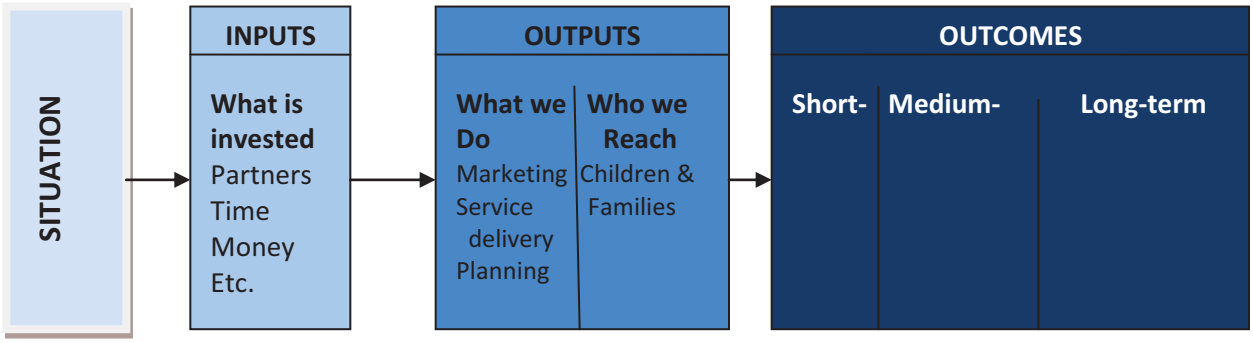
A logic model is a "map" or illustration of what you do, why you do it, what you hope to achieve, and how you will measure achievement; it includes the anticipated outcomes of the system of care, indicators for those outcomes, and the measurement tools used to evaluate the outcomes. The model describes logical links between resources, activities, short, intermediate, and long-term goals related to a specific issue or problem.

[112] Child Welfare Information Gateway. (2008) *Systems of care.* Accessed at www.childwelfare.gov/pubs/soc/
[113] Ibid

Section 7 ACCOUNTABILITY

Logic models are narrative or graphical depictions of processes in real life that communicate the underlying assumptions upon which an activity is expected to lead to a specific result. Logic models illustrate a sequence of cause and effect relationships.[114]

Elements of a Logic Model[115]



Begin building the logic model by asking the following questions in the following sequence:

- What is the current situation we intend to impact?
- What will it look like when we achieve the desired outcomes?
- What behaviors need to change for those outcomes to be achieved?
- What knowledge or skills do people need before the behavior will change?
- What activities need to be performed to cause the necessary learning?
- What resources will be required to achieve the desired outcomes?

The *situation* statement communicates the relevance of the work:

- Statement of the problem
  - What are the causes
  - What are the social, economic , and/or environmental symptoms of the problem?
  - What are the likely consequences if nothing is done to resolve the problem?
  - What are the actual or projected costs?
- Who is affected by the problem
  - Where do they live?
  - Who depends upon them?
  - How are they important to the community?

- Who is interested in the problem?
  - Who are the stakeholders?
  - What other projects address this problem?

[114] McCawley, P. *The logic model for program planning and evaluation.* University of Idaho Extension. Accessed at www.uiweb.uidaho.edu/extension/LogicModel.pdf
[115] Ibid

Section 7 ACCOUNTABILITY

The situation statement establishes a baseline for comparison for outcome measures. A description of the problem and its symptoms provides a way to determine whether change has occurred.

Inputs are those things that are invested in the program, such as knowledge, skills, or expertise:

- Human resources
  - Collaborative partners
  - System of care staff
  - Service delivery staffs
- Fiscal resources
  - Grant funding
  - In-kind resources
  - Fund raising
  - Donations

Outputs are the activities and the people served:

- Activities
  - Outreach and engagement
    - marketing
  - Service delivery
- Children and Families
  - Characteristics and behavior
  - Number of children served
  - Number of services/activities attended by participants
  - Level of satisfaction participants express for the service delivery

Outcomes answer the question "what happened as a result of the program?"

- Short-term
  - Awareness – people recognize the problem
  - Knowledge – people understand the causes and potential solutions
  - Skills – people possess the necessary skills to resolve the problem
  - Motivation – children and families have the desire to effect change, professionals have the desire to change practices
  - Attitude – people believe their actions can make a difference
- Intermediate-term
  - Changes in service delivery practices
  - Behaviors exhibited by people, organizations, agencies
  - Changes in organizational policies
  - Changes in management strategies
- Long-term
  - Improved conditions for children and families – social, educational, economic, etc.

Section 7 ACCOUNTABILITY

Measuring (Evaluation)

Once the logic model is developed, the next step is to determine how and when data will be collected to measure outcomes. Who will be responsible for data collection, how will it be collected.

Before you can know that the program "worked" or produced the desired outcomes, you need to know if it was implemented as planned. Process indicators should be designed to provide a measurable response to questions such as:

- Were specific inputs made as planned, in terms of quantity and quality?
- Were specific activities (outputs) conducted as planned?
- Was the desired level of participation by children and families achieved, in terms of numbers and characteristics of participants?
- Did children and families express the degree of satisfaction expected?

Outcome indicators must also be identified appropriate to the desired short-, intermediate-, and long-term outcomes, and should provide a measurable response to questions such as:

- Did participants demonstrate the desired level of increased knowledge, awareness, or motivation?
- Were improved management practices and policies adopted? Were service delivery programs improved?
- To what extent were social, economic, or environmental conditions affected?

What information will different groups want?[116]

GROUP	TYPICAL QUESTIONS	EVALUATION USE
Advisory Board, SOC staff	Are we reaching our population of focus? Are our families satisfied with our program? Is the program being run efficiently? How can we improve our program?	Programming decisions, and day-to-day operations
Youth and Families	Did the program help us and families like us? What would improve the program?	Decisions about family engagement and retention
Community members	Is the program suited to our community needs? What is the program really accomplishing?	Decisions about community participation and support

[116] W.K. Kellogg Foundation. (2004). *Logic model development guide.* Battle Creek, MI: W.K. Kellogg Foundation

Public Officials	Who is the program serving? What difference has the program made? Is the program reaching the population of focus? What do participants think about the program? Is the program worth the cost?	Decisions about commitment and support Knowledge about the utility and feasibility of the program approach
Funders	Is what was promised being achieved? Is the program working? Is the program worth the cost?	Accountability and improvement of future grant-making efforts

Applying

The feedback from the measuring/evaluating process should be applied to program improvement through a continuous quality improvement (CQI) process.

CQI process should help the Advisory Board and system participants to:

- Assess whether implementation is following what was proposed in the logic model
- Identify areas where plans have deviated and why
- Reassess priorities or expectations
- Identify and implement improvement plans

To advance from data collection and evaluation to practicing accountability, the information must be shared and used to improve the system. Communicating information about performance to all stakeholders is critical. Small indicators may show improvement long before large system-wide results can be seen. Even when progress is not readily apparent, sharing information advances system improvement by:

- Creating early opportunities to review and revise system improvement activities that are ineffective
- Allowing a wide group of stakeholders to participate in improvements
- Demonstrating the system's willingness to be transparent to community partners, service delivery systems, and all stakeholders
- Demonstrating to those collecting the data how the information is used and how improvements in practice can generate improvements in outcomes
- Making accountability a routine part of system of care operations[117]

[117] National Technical Assistance and Evaluation Center for Systems of Care. (2010). *Accountability.* Accessed at www.childwelfare.gov/pubs/acloserlook/accountability/accountability1.cfm

Section 7 ACCOUNTABILITY

Helpful Information Resources

www.childwelfare.gov/pubs/acloserlook/accountability/accountability1.cfm - website for the Child Welfare Information Gateway, article on Accountability

www.wkkf.org/knowledge-center/resources/2010/Logic-Model-Development-Guide.aspx - A Logic Model Development Guide created by the W.K. Kellogg Foundation, covers all the basic information needed to develop a logic model.

www.childwelfare.gov/management/effectiveness/logic_model.cfm - website for Child Welfare Information Gateway, information on logic models, and link to tools

http://toolkit.childwelfare.gov/toolkit/ - website for Child Welfare Information Gateway, direct link for the Logic Model Builder

http://digitallibraries.macrointernational.com/gsdl/collect/evaluati/index/assoc/HASHce52.dir/doc.pdf - Getting to Outcomes in Systems of Care: 10 Steps for Achieving Results-Based Accountability – a structured process for planning, implementing, and evaluating systems of care with a focus on accountability

www.ojjdp.gov/grantees/pm/logic_models.html - website for the Office of Juvenile Justice and Delinquency Prevention, information on logic models and links to samples

Section 8 SUSTAINABILITY

What is Sustainability?

Sustainability refers to the system of care's capacity to support and maintain its activities over time.[125] The ultimate goal of systems of care development is to put an infrastructure and philosophy in place that can be maintained as grant funding decreases. ***System of care communities must plan for sustainability from the initial grant award.***

Resources to sustain the collaborative system of care are available from four main sources that work together and independently: money, people, goods, and services.[126]

Strategies for sustainability include:

- Infusing system of care values and principles in policies, practices, and structures across agencies and the community (people and services)
- Generating support and an advocacy base through social marketing (money, people, goods)
- Improving financing strategies, such as fund-raising, obtaining in-kind funding, and submitting competitive grant applications (money, people, goods, and services)

What should be sustained?

- Philosophy of system of care – family-driven, youth-guided, community-based, culturally and linguistically competent, collaboration
- Infrastructure – the collaborative group, the provider network, focal point for system management, capacity to collect and utilize data, capacity to provide training on system of care and effective interventions (strategies for sustaining the collaborative are presented in Section 2)
- Service and Supports for children and families

Financing Strategies across Systems

Effective systems of care try to achieve several goals related to financing through restructuring financing systems:

- Maximize federal reimbursement to generate new dollars for the SOC;
- Redirect dollars from costly "deep-end" services to home- and community-based services and supports;
- Redirect dollars and other resources from traditional systems and traditional ways of doing business to the SOC through realignment and reallocation of spending; and
- Identify new funding streams to support the SOC.

Fund-raising

Fund raising is the proactive process of marketing the critical services a system of care provides to the community and generating financial support for these services.[127] For many partnerships, fund-raising is

[125] Butterfoss, F.D. (2007).
[126] Ibid.

seen as a lesser priority over the other work to be done; however, no organization can function without money, and fund-raising is essential for providing the resources for community activities.[128]

Resource Development Work Group (Financial Sustainability Team)

A resource development team, a workgroup of the Advisory Board/collaborative, should be formed to help obtain the resources needed and to ease the transition from one funding source to another, such as at the end of a grant period. This group is ideally formed when the collaborative first begins their work, but is essential as grant funding is deceased. Active, committed, knowledgeable collaborative partners who are willing and able to speak publicly on behalf of the system of care are essential to fund-raising efforts.

As with other collaborative work groups, this group should develop a work plan for resource development that provides for short- and long-term objectives, strategies, and action steps to get and keep financial resources. The plan should include obtaining direct funds through new and continuing competitive grants from public sources, national organizations, foundations, and corporations, and raising funds in the community through special fund-raising events or individual donations.[129]

Four Keys to Financial Sustainability[130]

Funding is the lifeblood of a nonprofit. It is the most critical element to long-term sustainability yet the one that the vast majority of nonprofits shun. During the grant period it is critically important to begin creating and implementing a plan for financial success.

Here are four keys to that success:

1. Develop a 4-Step sustainability strategy based upon building and maintaining strong relationships. Successful long-term funding is built upon these relationships.

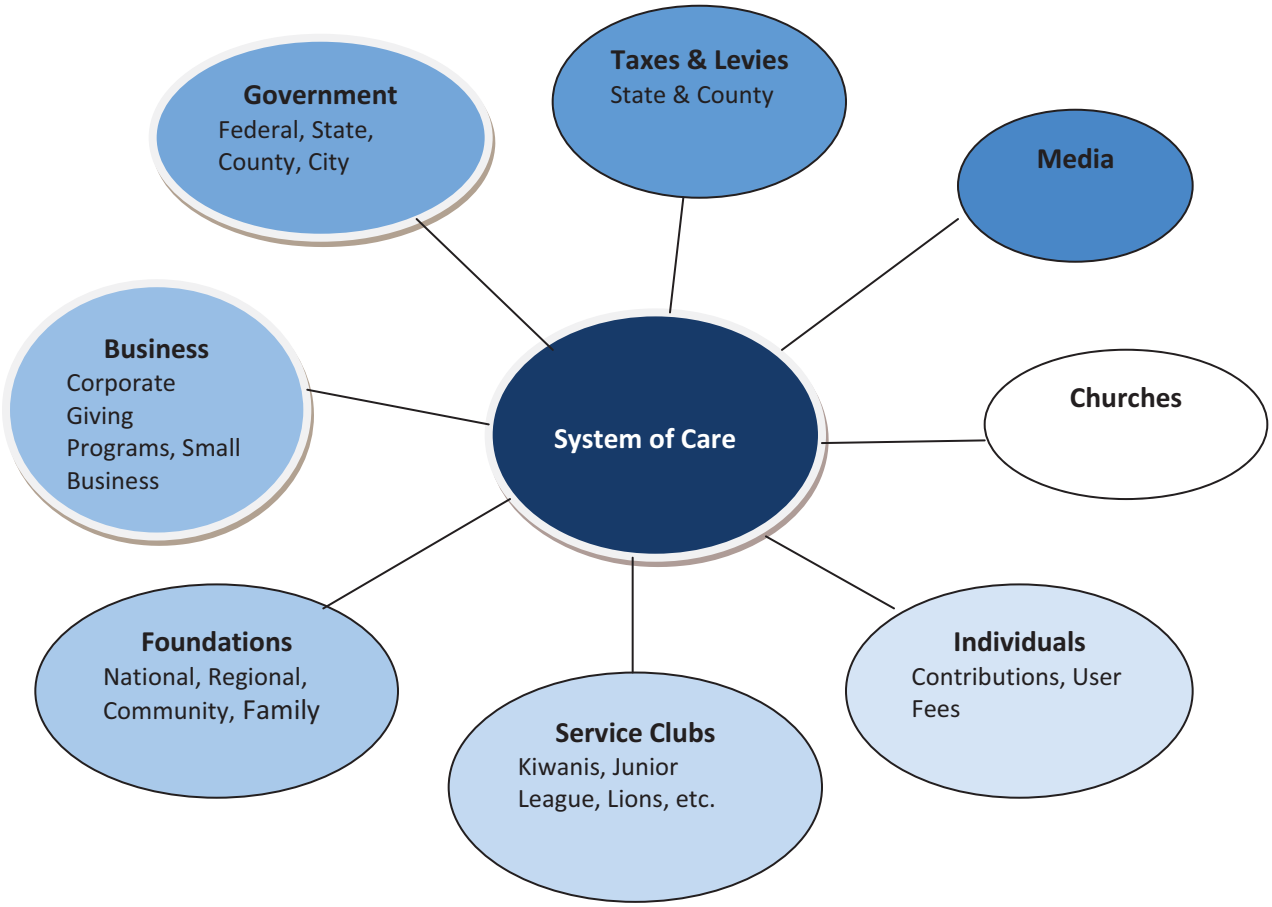
2. Build a Resource Development/Sustainability Team. Fundraising is a team sport. If you do not identify the right people for this team you will not succeed…it's that simple. Learn where to find these team members and what they will do to help you in implementing your funding strategy.

3. A Case for Support is the primary document that you will use to let people know what you do, how you do it, why you do it, your past successes and future plans.

4. Develop an annual Strategic Fundraising Plan with your sustainability team, laying out in a logical format what fundraising steps need to be taken, who is responsible to do it and the due date for completion. Without such a plan fundraising would simply be put on the back burner. This plan keeps it front and center where it must be.

[127] Ibid.
[128] Ibid.
[129] Ibid.
[130] Bumpass, F. (2010). Ministry Funding Solutions.

Where to Look for Funding and Other Types of Support[131]



[131] Pires (2008)

The Five Foundational Principles to Raising Funds[132]

Fundraising is not about YOU! It is about your organization, the people you serve and your financial partner prospects. You are raising funds to make a change in the world.

Sustainable funding is built upon strong personal relationships. Relationships take time and are intentional. Many Program Administrators don't believe that they have enough time to be involved in the funding process. Yes, they are very busy. But funding comes from relationships, and you are an important person in the community, one that key financial prospects want to get to know.

Yesterday's donors have become today's investors who require two things from you:

- Return on investment. In the nonprofit world that means changed lives. Are you making a difference in the lives of those you serve?
- A relationship with you and your organization.

The best time to raise money is when you don't need it. Why? Because you don't want to appear to be desperate for funding. That always encourages potential donors. Raising funding when you are pressed about meeting the budget makes you look desperate and who wants to invest in a desperate investment (your organization)?!

The board/policy council/sustainability team must lead in order for others to follow. You will find it very difficult to fundraise if the key players in your organization do not financially support it.

[132] Bumpass, F. (2010) Ministry Funding Solutions.

Motivational Reasons Why People Give[133]

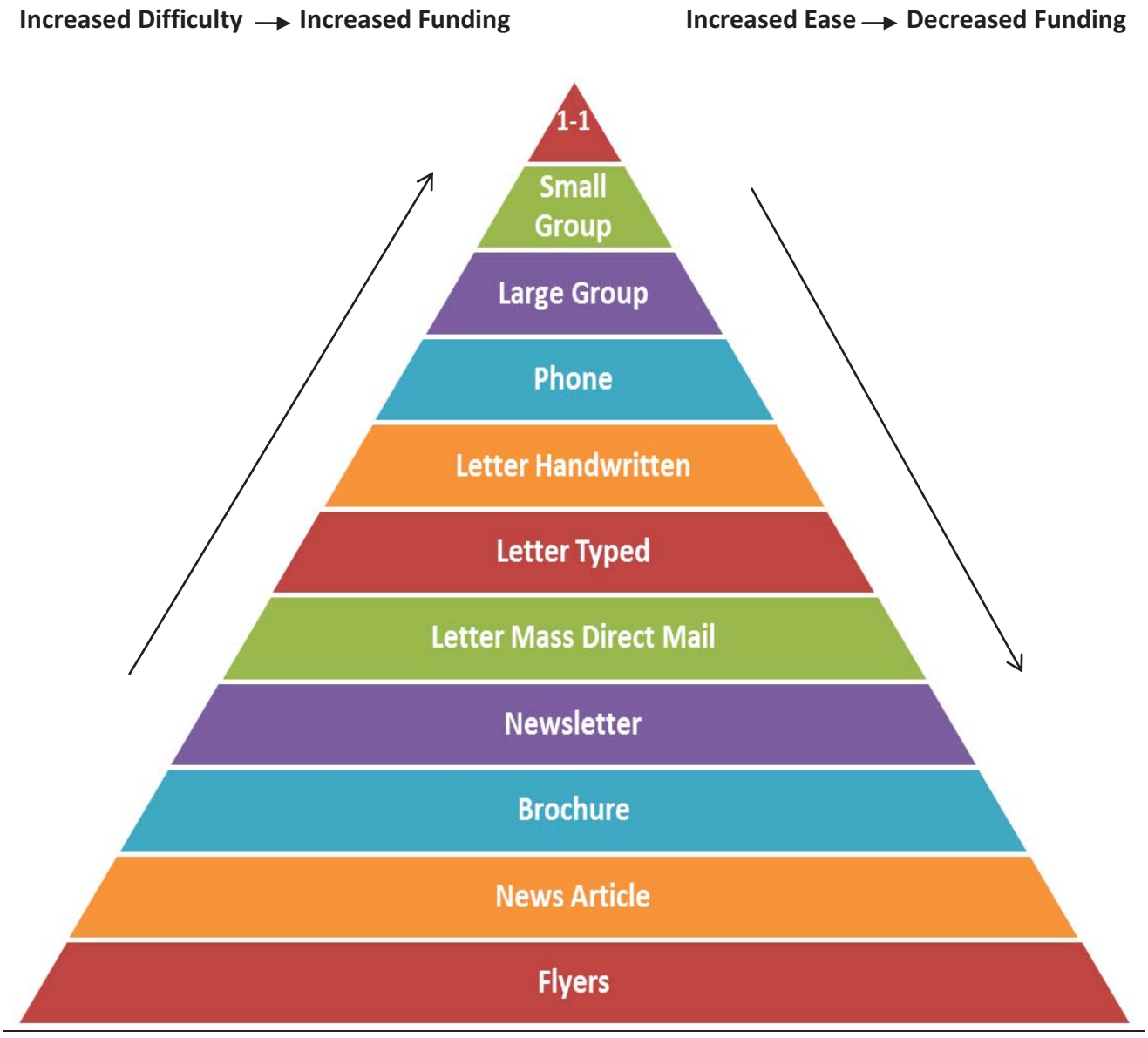
People give when they catch a great vision, not when they see a great need. If having a great need was all that was required to be fully funded, then all nonprofits would be fully funded because they all have great needs to be met. Having a convincing Case for Support will allow you and your sustainability team members to "sing from the same song sheet" when presenting your vision to prospects.

People give when their values match those of your organization. Not everyone will be as excited about what you do as you are. That's OK. Most people raising funds fear hearing the small word, "No." Get used to it…that's part of the process. Your responsibility is to clearly present your organization (using your Case for Support) and allow the prospect to determine whether or not they believe in and value what you are doing.

People give when they are involved and have a sense of **ownership**. The best investors are those who are most closely related and committed to your cause, involved through volunteering with your organization, receiving your newsletter, etc.

[133] Ibid.

Law of the Relational Pyramid



This chart shows the reality that the more personal you make the "ask" for funding, the more money you will receive, and the fewer "No's" will be received. Asking for funding in person, one-on-one, will result in more funding.[134]

[134] Ibid.

Social Marketing

Social marketing strategies can be used to promote the system of care by focusing on education (improving knowledge, attitudes, and practices); developing an advocacy base; cultivating leaders and champions for system of care approaches; improving the quality of services; and linking the population of focus to needed services.

Social marketing is the use of marketing principles to influence human behavior for the purpose of improving health or benefitting society. While commercial marketing tries to change people's behavior for the benefit of the marketer, social marketing tries to change people's behavior for the benefit of the population of focus or society as a whole.[135]

Four essential elements of social marketing:

- Population of focus must be at the center of every decision made
- Focus is on voluntary behavior change
- Behavior change must be for the benefit of an individual, group, or population, not for profit or commercial gain
- If individuals are expected to give up, or modify an old behavior, or accept a new one, they must be offered something of value in return

The collaborative should publicize both the benefits of change and its efforts to make change easier. The role of the Advisory Board/collaborative is to know where community members stand in regards to awareness of the issue and readiness to take action, and then design messages that move them towards action.[136]

The "4 P's" of marketing:[137]

- Product - the product being marketed in systems of care is the philosophy - the core values and guiding principles of systems of care: Family-Driven and Youth-Guided, Community-Based, Culturally and Linguistically Competent
- Price – refers to the financial, emotional, psychological, and time costs of the collaborative, the service delivery system, and the population of focus and families; if the benefits out-weigh the cost, the likelihood of adoption of the "product" is greater
- Place – the way in which the product reaches the "consumer." For an intangible product, such as the values of systems of care, place is less specific and may refer to the channels through which "consumers" are contacted with information. Another element of "place" is deciding how to ensure accessibility to the system of care and to service delivery
- Promotion – refers to the utilization of advertising, public relations, and media advocacy; the focus of promotion is on creating and sustaining demand for the "product" – the system of care infrastructure

[135] Butterfoss, F.D. (2007)
[136] Ibid.
[137] Ibid

The "4 Additional P's" of social marketing:[138]

- Participation – incorporates the input of the population of focus in planning, developing, and implementing the services and supports it needs
- Partnership – or collaboration, when other organizations in the community have similar goals
- Politics – political diplomacy may be needed to gain support and deflect turf issues across agencies
- Policy – the use of regulations or policy to encourage the desired behavior; for example, child serving agencies and service providers should imbed the system of care values and principles in their policies

Marketing Campaign Development Tool[139]

Population of Focus	In order to assist this population of focus…..
Behavioral Change	Do this specific behavior…….
Benefits	The collaborative system of care will offer these benefits that the population of focus wants……
Strategy	And reduce these barriers (address the "P's") through these strategies : behavior change goals, service delivery, outcomes, resource needs

[138] Ibid
[139] Ibid

Helpful Information Resources

www.toolsofchange.com/en/programs/social-marketers/ – website for Tools of Change – review of social marketing, the four P's, social marketing in practice, case studies

www.financeproject.org – website for the Finance Project with links to publications specific to financing strategies, some downloadable, others for purchase

www.tapartnership.org/SOC/SOCsustaining.php - website for the Technical Assistance Partnership for Child and Family Mental Health, specific to sustaining systems of care, includes sustainability strategic planning template, self-assessment tool, and community examples

www.clasp.org – Fact sheets, policy solutions and presentations related to low income issues.

www.zerotothree.org

www.raconline.org/pdf/federal_funding_guide.pdf - "A Guide to Federal Resources for Youth Programs"

Section 9 GRANT WRITING

What are Grants?

Grants are awards of financial assistance from one entity (usually a government agency, a foundation, or a corporation) to a recipient (often a non-profit organization) to carry out a specific purpose that fits within the funding criteria of the grant-giving entity. Most grants require some level of compliance and reporting to the funder.[155]

Should the Community Partnership Apply for Grants?

Grants can be an excellent way to obtain funding. The community collaborative needs to fully understand the conditions, limitations, and restrictions that are often attached to grant funding and decide whether it is in the best interest of the collaborative and community to pursue grant funding.

Questions for Collaborative Members to Ask Themselves[156]	If Response is…..	Consider
What are the collaborative's long-term goals? Will the grant promote them?	Yes	Applying for the grant
	No	Other sources of funding
What are the tangible benefits in addition to the funding? Will the grant improve collaboration? Access to services? Improvement in services?	Yes	Applying for the grant
	No	Other sources of funding
Can the collaborative do the same work as well, or almost as well, without grant funding?	Yes	Other sources of funding
	No	Applying for the grant
Is the proposed project realistically within the capability of the collaborative and its partners? (management, record keeping, reporting, etc)	Yes	Applying for the grant
	No	Other sources of funding
Is the grant funding period conducive to the accomplishment of collaborative goals and objectives?	Yes	Applying for the grant
	No	Other sources of funding

[155] Butterfoss, F.D. (2007).
[156] Ibid

Section 9 GRANT WRITING

Grant Funding Sources

There are three main sources of grants: federal, state, and local government agencies; foundations; and private businesses/corporations. See the Helpful Information Resources at the end of this section for websites.

Writing a Grant Proposal

A successful grant proposal is planned, well-prepared, and concise. The process of preparing proposals depends on the funder; different funders require different formats and information. However, there are some basic components that applicants should be prepared to include:[157]

- Cover letter, title page, and summary or abstract
  - The cover letter should be on the lead agency's stationery and signed by appropriate officials. It should be no more than one page and describe the collaborative's interest and ability to successfully implement the proposed project.
  - The title page includes the project title, name of the collaborative and lead agency submitting the grant, agency address, beginning and ending project dates, and the total amount of funding requested.
  - The abstract or summary is generally a one- or two-page condensation of the problem statement, project goals, methods that will be used to implement and evaluate the project and the collaborative's capacity (expertise and resources) for carrying out the proposed project. The abstract is the key part of the proposal; it may, in fact, be the only part of the package that is carefully reviewed before the decision is made to consider the proposal any further. It is helpful to prepare the abstract after the proposal has been entirely developed to ensure the inclusion of all the necessary information to fully communicate the objectives of the project.
- Introduction of the organization
  - The collaborative describes its mission, history, and experience, emphasizing its strengths and contributions to the community in the topic area for which the funding is requested. Links to community partners and other resources should be highlighted and letters of support from partners should be obtained and included in the appendices.
- Problem statement
  - The problem statement is a key element of the proposal; it should be clear, concise, well-supported by the community assessment – including contributing factors of the problem (risk factors), and identify current approaches or solutions based on a review of the literature.
- Project description/design
  - The project description presents the details of program implementation, including the goals and objectives; it provides a "road map" that anyone should be able to

[157] Ibid

follow. Methods should describe in detail how the goals and objectives will be carried out over the course of the project. Tasks should be sequentially ordered with a timeline for development and implementation according to the months, quarters, years of the grant period. All activities listed in the timeline will inform and shape the budget request.

- Evaluation plan
  - The evaluation plan helps the collaborative, as well as the funder, assess whether objectives were met and whether the program's benefits/outcomes justify the cost. Two types of evaluation are used:
    - Process evaluation assesses the implementation of the project, emphasizing tasks to be completed
    - Outcome evaluation assesses the short- and long-term impact of the project
- Budget
  - The budget request may not exceed the amount of funding available in the grant. It is an estimate based on the goals, objectives, methods, and evaluation plan. The budget justification describes the need for each budget item requested. Funders expect to see true anticipated costs, not estimates. Common budget line items include:
    - Personnel – salaries and fringe benefits
    - Contract services
    - Equipment
    - Supplies
    - Travel
    - Other costs (communications, rent, utilities, etc)
- Plans for sustainability
  - Granting entities often expect a long-term plan for sustainability of the project because grant funds are time limited. Some grantors require a match of funding, either from the beginning of the award or at some future date.
- Appendices
  - Appendices provide supplemental, supporting information that does not belong in the body of the proposal; such information may include letters of support and resumes of key partners.

Reviewing Process for Competitive Grant Applications

It is imperative to follow the instructions in the Requests for Proposal (RFP) from the various funding entities. Most RFPs are prepared and disseminated to encourage eligible organizations to *compete* for funding. Grant reviewers will exclude any proposal that does not follow or clearly address the required guidelines or instructions.

Common Mistakes in Grant Applications[158]

Failure to follow application instructions	Unclear narrative or poor editing
Missing components	Weak or non-measureable objectives
Misplaced or missing content	Weak evaluation plan
Failure to use preferred terminology	Inconsistencies in the application
Missing references	Budget problems
Focus inconsistent with review criteria	Application arrives late
Narrative not in specified order or sections misnamed	

In general, reviewers will consider the following overall merits of the proposals:[159]

- **Technical quality** – has the applicant documented the need for the project in the proposed locality and among the population of focus? Are the objectives appropriate, significant, and feasible? Is the work plan practical? Are the strategies innovative, or do they represent business as usual? Is the evaluation plan of high quality and feasible? Is the project potentially replicable?
- **Skills and related experience of staff and organization** – do the organization and proposed personnel have the capacity to implement the project based on resumes, job descriptions, past experience, and partnerships with other agencies/organizations?
- **Cost and appropriateness of budget** – is the total cost within the guidelines, and is it reasonable, given the work to be done?

Common Elements Found in Winning Proposals[160]

Clearly defined needs and how those needs were identified
Intentions are well described – reader has clear sense of what will be done
Material is presented in a logical manner – sections are clearly identified and each need has a stated objective, activity, and evaluation statement
Written in positive terms

[158] Ibid
[159] Ibid
[160] Carnow, G. *What do winning proposals have in common?* Accessed at www2.scholastic.com/browse/article.jsp?id=4173

Does not overuse jargon and clearly defines terminology that is used

Detailed budgets that match the proposed program

Proposal "gives something back" - may develop a product, such as a screening instrument, or dissemination of knowledge learned

Follows all the guidelines in the grant or Request for Proposals

Professional looking presentation that follows the requirements in the grant

Not too short, not too long – as a rule of thumb, use the scoring guidelines to determine length; for example if the proposal is to be no longer than ten pages and requires an abstract, description, evaluation plan, and budget, and the scoring guidelines weight the evaluation section to be 20% of the final score, then 2 of the 10 pages should be devoted to evaluation.

Helpful Information Resources

http://grants.nih.gov/grants/grant_tips.htm - website for the U.S. Department of Health and Human Services; grant writing tips

www.epa.gov/ogd/recipient/tips.htm - website for the U.S. Environmental Protection Agency, tips on writing a grant proposal

www.federalgrantswire.com – listing of federal grants by agency, and by subject area

www.grants.gov – listing of federal grant opportunities

http://sparkaction.org/resources/37987 - grant-making foundations, community foundations, and corporate giving programs in the State of Georgia

APPENDICES

A. Collaboration Readiness Checklist

B. Board Self-Assessment

C. Big Tent Stakeholders Wheel

D. Family and Youth Engagement Tool

COLLABORATION READINESS CHECKLIST

1. **Context or Condtions for the Collaboration**

____The problem, issue we want to address requires a collaborative approach; it cannot be done effectively by one organization alone.

____We have sufficient resources or sponsorship to begin and implement the effort.

____We are aware of the qualities and resources needed for successful collaboration, and we believe we can obtain them.

2. **Organizational Self-Assessment for Collaboration (for partnering agencies)**

____We have organizational protocols for collaboration and have prepared our representative

____We have criteria for entering collaborations and selecting collaboration partners, and can use them to help us to commit to, or decline, collaboration opportunities.

____The goal of the collaboration is linked to our goals and priorities.

____We are aware of what might be a problem for our organization if we join the collaboration or if certain others participate, and we are prepared to address this.

____We are ready to meet the collaboration's expectations for participation and work.

____We are clear about the level of organization (for example, director, staff, board member) we will involve in this collaboration.

____Our proposed role in this collaboration is appropriate, given our resources and priorities.

____Appropriate leadership endorses our participation in this collaboration.

3. **Things to Discern About Potential Collaboration Partners**

____What are their organization mission and goals?

____What are their organization's philosophy, values, and cultures?

____What can they bring to the collaboration? Why is their involvement essential to the success of this effort?

____Why do they want to collaborate? What are their expectations of this collaboration's outcomes?

____Where does this collaboration fit within their organizational priorities?

4. **Things to Clarify About the Potential Collaboration**

____Is there a foundation of trust among the potential partners or members of this collaboration?

____What will collaboration success look like, and what will be the standards of practice?

____How will we evaluate the effort and make mid-course adjustments? Are the partners open to developing shared evaluaton criteria and conducting periodic evaluations to keep the project on course?

____What type and level of organizational representation is expected?

____How will the partners fulfill the different roles needed to make this collaboration function?

5. **Individual Role and Readiness for Collaboration**

____Within my own organization I have influence and expertise in these areas:

_____

_____

_____

____My agency's expectations for me as a representative in this collaboration are:

_____

_____

_____

I have authority, on behalf of my organization, to:

____Establish relationships
____Generate ideas
____Set policy
____Plan activities
____Implement activities
____Spend money
____Assign resources
____Commit staff time
____Sign position papers
____Evaluate
____Make recommendations
____Make organizational changes

Source: Rosenthal, B. Collaboration and Change, LLC in Butterfoss, F.D. *Coalitions and Partnerships in Community Health.* 2007. San Francisco: Jossey-Bass. p.47.

SYSTEM OF CARE (SOC)
ADVISORY BOARD SELF-ASSESSMENT

The role of an Advisory Board is to ensure that the system of care is providing high quality services which meet the needs of the community and the target population. To carry out this role, Advisory Boards have several responsibilities: establishing the mission, vision, and goals of the system; planning – including community needs assessment and developing sustainability strategies; assisting in the development of community-based care networks and integrated service delivery systems that function effectively; communication; accountability for quality of care; ensuring the system is managed effectively; advocacy and community change.

Self-assessment is a tool for Boards to utilize to ask themselves how well they are performing; self-assessment can help indicate where the Board's strengths lie, as well as where improvement may be needed. It is an important function that should be an ongoing part of evaluating the effectiveness of the Systems of Care Advisory Boards.

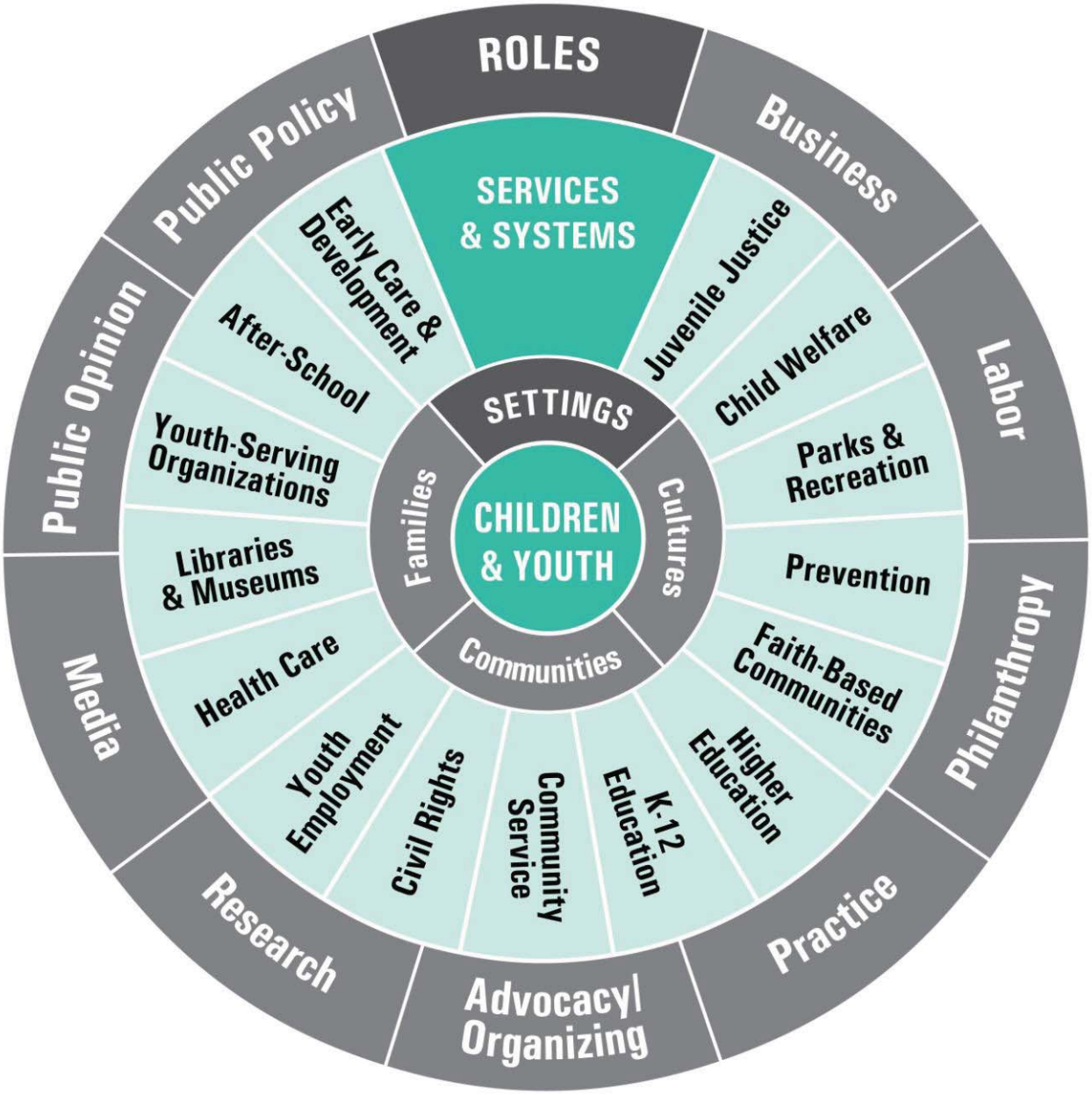
Using the scale below, each Board member should rate each component of your Advisory Board structure by checking the box you believe most appropriate.

Components/Functions of Collaborative Structure	Strong Always 5	Usually 4	Sometimes 3	Rarely 2	Weak Never 1	Not Yet Implemented 0
Members of the Advisory Board are representative of the community and the target population, with needed professional skills/talents and appropriate cultural and gender mix.						
Family and youth (as appropriate) are integral members of the Board.						
The Board consists of a workable number of members to function effectively and efficiently as a group.						
A term of membership on the Board is defined and a staggered recruitment process has been established.						
The Board has a regular meeting schedule that members can count on.						
The Board has active working committees, such as Evaluation, Sustainability that report regularly to the full Board.						
The Board has defined a method to choose officers.						
The roles, responsibilities, functions, relationships and authorities of the Board members and officers are in a written statement.						
A term of office is defined.						
Guidelines or by-laws for operation have been developed.						
The Board has the necessary information to arrive at responsible decisions.						

Components/Functions of Collaborative Structure	Strong Always 5	Usually 4	Sometimes 3	Rarely 2	Weak Never 1	Not Yet Implemented 0
Board members receive meeting notices, written agendas with appropriate materials well in advance of meetings.						
The Board receives an accurate record of deliberations made during its meetings through the timely distribution of minutes or meeting notes.						
The vision, mission and goals are developed by participation of all Board members, as well as other appropriate stakeholders.						
The Board seeks opportunities to communicate with the community regarding system services and programs and to inform and seek input to determine unmet needs.						
The Board utilizes data from the service delivery system to inform its decisions.						
The Board periodically re-evaluates and updates the vision, mission, and goals.						
The Board actively participates in fund-raising and development programs.						
Members share an understanding and respect for each other and their respective organizations – how they operate, their norms and values, their limitations and expectations.						
Members believe that they and their organizations will benefit from their involvement in the collaboration and that the advantages will offset costs such as loss of “turf”.						
Members are able to compromise.						
The Board has developed strategies around decision – making in the event that consensus cannot be reached.						
Effective processes exist for solving systemic and interpersonal problems.						
Members feel ownership of both the way the group works and the results and products of its work.						
The Board has established an effective means to promote open communications between the Board and the service delivery system.						

Big Tent Stakeholders Wheel

In your discussions with partners and teams, mark this wheel by hand.



KEY		Example
Top Level Managers		
Mid-Level Managers		
Front Line Workers		
Community, Parents and Youth		

BIG TENT STAKEHOLDERS WHEEL

Engaged Stakeholder Instructions:

Use the following chart to count who you engage with and at what level they are operating.

- **Column A:** List the Big Tent Partners you are working with by organizational name. Also, highlight and put a star (*) next to the stakeholders on your core team (if you have one).
- **Column B:** List the different services and systems, roles and settings that those specific stakeholders work in. Refer to and select from the Stakeholders Wheel on the flip side of this sheet. Add any categories that you think are missing from the wheel.
- **Column C:** Indicate the number of each type of participant under the applicable sub-headings.
- **Column D:** Rate each stakeholder on each engagement category and on overall engagement, from 1 (low) to 5 (high).

Target Stakeholder Instructions:

List who you want to engage that is not already at the table. If you do not have specific names or organizations, fill in Columns B and C only. Add extra rows as needed.

ENGAGED STAKEHOLDERS												
A	B	C						D				
BIG TENT PARTNERS BY ORGANIZATION	SERVICES & SYSTEMS, ROLES / SETTINGS	HOW MANY?						HOW ENGAGED? 1 (low) – 5 (high)				
		Top-Level Leaders	Mid-Level Managers	Front Line Workers	Community Members	Parents	Youth	Urgency	Commitment	Collaboration	Big Picture	OVERALL
Example 1: Boys and Girls Club	Youth-Serving Organization	1	2				2					
Example 2: City Council	Policy	1										
TARGET STAKEHOLDERS												

Assessing Family and Youth Engagement
Guidance

Family and Youth Engagement

Family Connection believes in the importance of developing partnerships among collaborative members, partnering programs, and the families/youth who participate in the programs, services, and activities that make up community strategies. One way to develop this partnership is to involve families at all levels of decision-making including 1) the services and supports that are available to families, 2) the financing of the services and supports, and 3) the changes needed at the community, state, or federal level in the rules and procedures that guide how services and supports are offered to families.

Family Connection's Definition of "Family and Youth Representative"

Families may represent themselves or may be represented by others who reflect the values and culture of the families in a target population. Representatives of families may include parents, caregivers, grandparents, youth, or other family members. The key to family representation is that the individual represents his or her own perspective or experiences, or the views of similar families in the community. **Family representatives do not attend meetings, speak, or commit resources on behalf of formal agencies, programs, or organizations.**

While all family members are important, a special effort should be made to include youth. They often have fresh views about the services and supports provided to families, and they are the parents and leaders of tomorrow. Not only do they bring a new perspective, their involvement provides a great opportunity for learning and, perhaps, helps them prepare for the challenges of parenthood and family life.

Overview for Using the Self Assessment

While recognizing the importance of family and youth involvement, challenges are expected. Therefore, collaboratives are encouraged to assess themselves to determine strengths and barriers related to partnering with families and intentionally develop plans that lead to greater participation by families in decision-making.

Family Connection has developed this assessment based on principles of family support as applied through best practices for family and youth engagement in the community collaborative. The completion of this assessment, which focuses on the active participation of and partnership with families and youth, can help collaboratives identify and celebrate successes, and identify and address areas needing improvement.

In addition, the assessment helps communities move toward success in meeting the "Georgia Family Connection Standards for Excellence". There are two "core" standards indicators for excellence that relate to family and youth engagement:

1)Collaborative has family members participating in activities of the collaborative.
2)Collaborative actively seeks input and representation of family members.

The findings can also provide critical guidance as the collaborative seeks to aim higher and achieve more of the "developmental" indicators in the "Georgia Family Connection Standards". There are four "developmental" standards indicators:

1) Collaborative uses tool to assess itself on family support principles and family engagement at least once every three years.
2)Collaborative has developed a written plan for family engagement.
3)Family member or parent leader serves on governing board or other committee of collaborative
4)Collaborative involves families in the planning process, program implementation, and designing and evaluating strategies.

Process: As you begin to use this self-assessment, remember the real purpose is not to score your level of family and youth engagement. Rather, it is to provide a vehicle for discussion and planning. There are many ways this tool can be used and two ways are outlined below:

- **In one meeting**: Members of the collaborative, *including family and youth representatives,* may complete the total self-assessment individually, and then the collaborative, as a whole, can discuss the responses as a group, using the guiding questions below.
- **In multiple meetings:** The collaborative, *including family and youth representatives,* may devote a portion of several meetings to rating and discussing sections of the assessment, then making plans based on the discussion. If you choose this alternative, you might consider grouping the sections as follows:
  - **Sections 1-4** deal with the overall collaborative's basic approach to engaging families (commitment, involvement in decision making, representativeness of families and youth involved, and communication with families and youth).
  - **Section 5** deals with the degree to which the various programs included in the Annual Plan or Strategy are consistent with Family Support Principles. Individual program managers should assess their programs separately and then share their observations and ideas for action.
  - **Sections 6-8** deal with the degree to which the collaborative has gone beyond "token involvement" by providing support so families and youth can be involved and nurturing shared decision-making so families and youth are active in leadership roles.

It is important to be honest and constructively explore the issues and questions surrounding family and youth involvement. Be frank about both strengths and weaknesses. When you are doing well, acknowledge it, and build upon your expertise in that area to improve your overall effort. When you are not doing well, acknowledge that, and work towards a solution to the more difficult issues. The purpose of this self-assessment is not to grade you or judge your group's effort, but to provide a **basis for reflection and ongoing growth.**

Discussion Questions: Following the completion of the assessment, the following questions may be used to guide the discussion:

Strengths and Struggles

1. What are the collaborative's strongest areas?
2. What has allowed you to improve in those areas?
3. How can you use these strengths to improve the rest of your effort?
4. In what areas is the collaborative struggling?
5. What can the collaborative do to improve?
6. What do families in the community say? Have you utilized their suggestions?

Relevance and Importance of Various Family Engagement Categories

7. How many items did you mark/consider "Not Applicable" or "Low Importance"?
8. Why did you consider these "Not Applicable" or "Low Importance"?
9. Were there items you considered of "High Importance" but are not implementing?

Taking Action as a Collaborative

10. What are your top priorities for action?
11. What are the next immediate steps you can take?
12. What is your long-term plan for engaging and sustaining the involvement of families and youth?

Using the Assessment to Guide Action - Deciding where to focus your energy.

Scan the assessment or the section of the assessment you're working on.

- If you have a number of areas where the collaborative is implementing at the "***none***" or "***some***" level, you might consider choosing to focus your energy first on the activities that the collaborative considers of "***high***" or "***moderate***" importance.

- If your collaborative thinks it is ***highly important*** that the collaborative have by-laws that provide for parent/family and youth positions on the governing body and that family and youth members actually participate in those roles, **but** it isn't happening – the implementation level is "***none",*** the collaborative needs to discuss how to make it happen. It might be relatively easy to change the by-laws, but it will take some creative thought and effort to insure the families actually get involved and fulfill those roles.
- If your collaborative has a high number of actions considered "***low*"** or "***moderate*"** importance, you might consider spending time discussing why so many principles of family support are considered less important. If the discussion points to collaborative members not really understanding the value of embracing family support principles, consider inviting an external resource person who might share examples of how highly involved families and parents have made a difference in the quality of life for families in their experience. If this experience is enlightening, then the collaborative might consider additional small steps for building their capacity to overcome obstacles to family and youth engagement.
- If your collaborative assessment shows many actions, especially in Sections 1-4, are being implemented at the "***most*"** level, consider focusing attention on Sections 6-7, where efforts are definitely beyond the basic.
- **On Section 5,** if the collaborative/program partners have a number item considered of "***low*"** importance, at the "***none*"** (not at all) implementation level, the collaborative might consider sponsoring a local training on family support principles and their value in program leadership.

Assessing Family and Youth Engagement
Assessment Tool

Instructions: Each statement represents an action that the collaborative might be taking to engage families and youth fully in the work of the collaborative. **For each statement:**

- First, indicate **how important** you think that action is by rating the degree of importance. (**Low -** for low importance; **Mod -** for moderate importance; **High -** for high importance)
- Then, indicate the **degree to which your collaborative is implementing the action**. **(None -** for not at all; **Some -** for sometimes; **Most -** for most of the time)

Collaborative's Overall Approach to Family and Youth Engagement

	Degree of Importance **Low/Mod/ High**	***Degree of Implementation*** **None/ Some/Most**
1. The collaborative makes a commitment to family and youth engagement by:		
a. taking the time to develop an understanding of the value of meaningful family and youth engagement.		
b. seeking guidance from families, youth, and individuals with experience in overcoming the obstacles to meaningful engagement.		
c. developing steps to actively involve families and youth.		
2. The collaborative encourages and involves families and youth in the decision-making process by:		
a. cooperatively developing all plans with families and youth.		
b. actively seeking and using the input of family and youth members in the planning process and designing strategies.		
c. meeting regularly at times convenient to participating family and youth members.		
d. ensuring the decision-making process is clear and understood by family and youth representatives.		
e. having families participate in the completion of the annual collaborative Self-Assessment.		
3. The collaborative insures appropriate representation and diversity by:		
a. recruiting and engaging families and youth who have not typically been involved in decision-making or other kinds of family and youth involvement.		
b. having a membership that is representative of the larger community in terms of race, culture, language, income and education.		
c. having strategies for promoting youth involvement as well as parent involvement, trying to ensure that youth have a stake and a voice in areas important to them.		
4. The collaborative communicates clearly, frequently and effectively with family and youth members by:		
a. asking for regular feedback from family and youth members about how welcome and comfortable they feel.		
b. providing information to family and youth participants in a timely manner so that they can prepare for meetings and other events.		
c. providing information in all the languages spoken in the group.		
d. intentionally developing trust relationships between families and professionals so that power is shared, opinions of family and youth members are respected, and professionals and families work together to make family and youth recommendations a reality.		

Principles of Family Support Programs in the Annual Plan

	Degree of Importance Low/Mod/ High	*Degree of Implementation* None/ Some/Most
5. The programs that are a part of the collaborative's Annual Plan/Strategy are consistent with the principles of family support. (The handout, *Principles of Family Support Practice,* should be available for review.)		
Within these programs:		
a. staff, families, and youth work together in relationships based on equality and respect.		
b. staff enhances families' capacity to support the growth and development of all members – adults, youth, and children.		
c. families and youth are resources to their own family members, to other families, to programs, and to communities.		
The programs in the Annual Plan:		
d. affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society.		
e. are embedded in their communities and contribute to the community-building process.		
f. advocate with families and youth for services and systems that are fair, responsive, and accountable to the families served.		
g. work with families and youth to mobilize formal and informal resources to support family and youth development.		
h. are flexible and continually responsive to emerging family, youth, and community issues.		
i. model family support in all program activities, including planning, governance, and administration.		

Going Beyond "Token Involvement"

	Degree of Importance Low/Mod/ High	*Degree of Implementation* None/ Some/Most
6. The collaborative SUPPORTS the involvement of families and youth by:		
a. reimbursing families and youth for their time, expenses, and transportation to events organized and/or provided by the group.		
b. providing or ensuring the availability of high-quality, flexible child care that meets the needs of family and youth members, allowing them to participate in meetings and other events.		
c. creating opportunities for families and youth to engage in peer networking and support.		
d. offering training for professionals, families, and youth, which are co-facilitated, by family/youth members and staff, on how to work collaboratively with each other.		
e. offering opportunities to families and youth that encourage their personal development of skills and expertise for collaborative and community leadership.		
f. matching "veteran" family and youth partners with inexperienced ones to ensure that new members feel supported in their roles.		
g. recognizing the contributions of family and youth members.		
7. The collaborative seeks true SHARED DECISION MAKING by:		

	Degree of Importance Low/Mod/ High	*Degree of Implementation* None/ Some/Most
a. ensuring collaborative by-laws provide for parent/family/youth positions on governing body and that family and youth members participate in that role.		
b. ensuring that family and youth members on decision-making bodies have full voting rights.		
c. having multiple family and youth members on decision-making bodies.		
d. having family and youth members select their own representatives for decision-making bodies.		
e. making sure families and youth have an equal voice in the most important decisions; including hiring staff, setting policy, and spending money.		
f. having families and youth work with the collaborative to set specific and attainable goals for involving families and youth in the policy-making and decision-making aspects of the collaborative.		
g. regularly discussing how decisions affect progress toward inclusiveness and cultural competence.		
h. devoting resources, such as money and staff time, to family and youth involvement.		
i. using the quality of family and youth involvement, (e.g. intensity and meaningfulness of involvement) as one of the measures of success for the collaborative.		
j. developing and implementing an action plan to increase the frequency, intensity and meaningfulness of family and youth involvement following this assessment.		
8. Families and youth are involved in LEADERSHIP roles in the collaborative by:		
a. chairing committees.		
b. serving as board members.		
c. conducting publicity and outreach.		
d. developing strategies.		
e. reviewing grant proposals.		
f. advocating and presenting to policymakers.		
g. evaluating/reviewing materials.		
h. recruiting new families and youth.		
i. allocating resources.		
j. representing the collaborative/programs in the community.		
k. participating in fundraising.		